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ARIZONA STATE BOARD OF PHARMACY
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www.azpharmacy.gov

FOR AGENCY USE ONLY							
ASBP Approval:		Permit No.:		Fee:		Receipt No.:	
Effective Date:		Certificate Mailed:		Check No.:		Check Date:	
Fee From:		Fee To:					

APPLICATION FOR PHARMACY PERMIT

(Call Board Office for Fee Information)

Check appropriate type of operation: ☐ Chain ☐ Hospital ☐ Government ☐ Independent ☐ Limited Service ☐ Non-Resident

Business Name:					
Address:					
	(Street and Number)	(City)	(County)	(State)	(Zip)
	(Phone Number)	(Fax)	(E-mail)		
Mailing Address (if different):					
	(Street and Number)	(City)	(County)	(State)	(Zip)
Owner(s) info:					
	(Name) If corporation or partnership, attach a list of officers or partners on a separate sheet, including name, title and address.		(Phone)	(Fax)	
Date business started / opening:			Square Footage:		

Application submitted due to change in ownership?	☐ No	☐ Yes	If yes, give former owner's name, AZ permit number, and permit name (if different):
Other trade or business names used:			
Have you conducted a similar business in any other jurisdiction?	☐ No	☐ Yes	If yes, state under what names and locations:

Has the owner, or any corporate officer or active partner ever been convicted of an offense involving moral turpitude, a felony offense, or any drug-related offense or has any currently pending felony or drug-related charges?

☐ No	☐ Yes	If yes, indicate charge, conviction date, jurisdiction, and location:

Has the owner, or any corporate officer or active partner ever been denied a pharmacy permit in this state or any other jurisdiction?

☐ No	☐ Yes	If yes, indicate where and when:

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FACILITIES LOCATED IN ARIZONA: the following is required:

a) Floor plan. Include plans or construction drawing showing facility size and security adequate for the proposed business.

b) Zoning. Include documentation of compliance with local zoning laws.

c) The following individuals will be present at the Arizona State Board of Pharmacy meeting when application is submitted for approval:

i) person named above as owner, if non pharmacist

ii) person named below as Pharmacist-In-Charge

FACILITIES LOCATED OUTSIDE ARIZONA: the following is required:

a) Attach a photo copy of license / permit issued by State of domicile.

b) List Pharmacist-in-Charge below.

Name of Pharmacist-In-Charge:	
License number:	
Expiration date:	
Emergency phone number:	

To the best of my knowledge and belief the foregoing application is true and current in all respects.

(Signature of Owner, Corporate Officer or Manager) (Title) (Date)