

BOARD OF PHARMACY

REQUIREMENTS AND INSTRUCTIONS FOR FILING - MISCELLANEOUS PERMIT

Access this form via website at: www.hawaii.gov/dcca/areas/pvl

Miscellaneous Permits - ACTIVITIES COVERED UNDER THIS PERMIT

Check Business Intended on Application:

- Sale of any prescription drugs at public auction or sale of any prescription drugs at private sale in a place where public auctions are conducted.
- Distribution or dispensing of any prescription drug samples to other than physicians, druggists, dentists, veterinarians and optometrists for use in their professional practice.
- For wholesalers to sell, distribute or dispense any prescription drug to other than pharmacists, physicians, dentists, veterinarians or optometrists.
- For any wholesale prescription drug distributor to sell or distribute medical oxygen to a physician, pharmacist, medical oxygen distributor, patient or patient's agent pursuant to a prescription or emergency medical services for administration by trained personnel for oxygen deficiency and resuscitation.
- For any medical oxygen distributor to supply medical oxygen pursuant to a prescription order.
- For any person, as principal or agent to conduct or engage in the business of preparing, manufacturing, compounding, packing, or repacking any drug.
- For any out-of-state pharmacy or entity engaging in the practice of pharmacy, in any manner to distribute, ship, mail or deliver prescription drugs or devices into the State.

DOCUMENTS TO BE SUBMITTED

Business Registration (BREG) Documents

- **IF facility is located in this State** and the applicant is a corporation, partnership, LLC or LLP, submit proof to show that the entity is properly registered with the Business Registration Division (BREG), Department of Commerce and Consumer Affairs, State of Hawaii, P.O. Box 40, Honolulu, HI 96810. *(Please write to them for the proper forms, call (808) 586-2727, or visit their website at: www.businessregistrations.com/home.html to order Certificates of Good Standing, forms, etc.):*
 - If the entity has been registered in this State for LESS THAN (1) YEAR, **ATTACH** a "**filed-stamped**" copy of the document filed with BREG; or one of the certificates mentioned below.
 - If the entity has been registered in this State for MORE THAN ONE (1) YEAR, **ATTACH** a current "**Certificate of Good Standing**" or "**Certificate of Qualification**" issued not more than one year ago.
- **IF facility is located in this State** and you are planning to use a trade name, **attach** a current "filed-stamped" copy of the "Application for Registration of Trade Name" approved by the Business Registration Division of the Department of Commerce and Consumer Affairs. You may contact them at (808) 586-2727.

Business Formerly Owned by Someone Else

Permits are not transferable. If the business was formerly owned, you must apply for a new permit and submit the required documents, including a letter of verification from the former owner that the business entity has been bought with the effective date of sale.

Out-of-State Pharmacy

1. **Complete** location, names and titles of all principal officers, partners, managers, etc. on attached application;
2. **Provide** a statement attesting that the applicant or any personnel of the applicant has not been found in violation of any state or federal drug laws, including the illegal use of drugs or improper distribution of drugs;
3. **Attach** official verification (original document with seal) of the following documents from the appropriate state regulatory agency or Board of Pharmacy of the state in which the pharmacy is domiciled (home state):
 - Verification of pharmacy license, permit or registration, including license number, effective and expiration dates, record of disciplinary action (if any); and
 - Verification of license, permit or registration, including license number, effective and expiration dates, record of disciplinary action (if any) for all pharmacists employed. If there are a considerable number of pharmacists employed, a list format is acceptable and preferable, provided that all of the requested information is included.

FEES Make check payable to *COMMERCE & CONSUMER AFFAIRS for the applicable fees:*

If applying for license in an EVEN-NUMBERED year, pay \$295**
*(*Application fee-\$100, License-\$50, Compliance Resolution Fund-\$70, 1/2 renewal-\$75).*

If applying for license in an ODD-NUMBERED year, pay \$185**
*(*Application fee-\$100, License-\$50, Compliance Resolution Fund-\$35).*

**Non-refundable application fee.*
***ALL licenses expire on December 31, ODD-NUMBERED years and are subject to renewal regardless of license issuance date.*

NOTE: *One of the numerous legal requirements that you must meet in order for your new license to be issued is the payment of fees as set forth in this application. You may be sent a license certificate before the payment you sent us for your required fees is honored by your bank. If your payment is dishonored, you will have failed to pay the required licensing fee and your license will not be valid, and you may not do business under that license. Also, a \$25.00 service charge shall be assessed for payments that are dishonored for any reason.*

If for any reason you are denied the license you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes. Your written request for a hearing must be directed to the agency that denied your application, and must be made within 60 days of notification that your application for a license has been denied.

CONTROLLED SUBSTANCES Register with the Department of Public Safety, Narcotics Enforcement Division. Be advised that states may have different substances listed in their schedules of controlled substances. For information, contact:

Department of Public Safety
Narcotics Enforcement Division
3375 Koapaka St., Ste. D100
Honolulu, HI 96819
Telephone: (808) 837-8470

LAWS & RULES PUBLICATION The license holder is held accountable for knowing and complying with the laws and rules as failure to comply may result in disciplinary action.

To obtain copies of the following laws and rules, send a written request to: *Board of Pharmacy, Commerce & Consumer Affairs, P.O. Box 3469, Honolulu, HI 96801.*

- Chapter 461, Hawaii Revised Statutes, Pharmacy & Pharmacist
- Title 16, Chapter 95, Administrative Rules, Pharmacists & Pharmacies
- Chapter 328, Hawaii Revised Statutes, Food, Drug, Cosmetics
- Chapter 329, Hawaii Revised Statutes, Controlled Substances
- Chapter 436B, Hawaii Revised Statutes, Professional and Vocational Licensing

The laws and rules are also posted on our website at: www.hawaii.gov/dcca/pvl. Click on "Pharmacy".

APPLICATION FORM Complete the attached form using a typewriter or print legibly in black ink. Complete and sign all sections of the application and forms. **Incomplete applications will delay the processing of your application.**

SOCIAL SECURITY NUMBER Your social security number is used to verify your identity for licensing purposes and for compliance with the below laws. For a license to be issued you must **provide your social security number or your application will be deemed deficient and will not be processed further.**

The following laws require that you furnish your social security number to our agency:

FEDERAL LAWS:

42 U.S.C.A. §666(a)(13) requires the social security number of any applicant for a professional license or occupational license be recorded on the application for license; and

If you are a licensed health care practitioner, **45 C.F.R., Part 61, Subpart B, §61.7** requires the social security number as part of the mandatory reporting we must do to the Healthcare Integrity and Protection Data Bank (HIPDB), of any final adverse licensing action against a licensed health care practitioner.

HAWAII REVISED STATUTES ("HRS"):

**SOCIAL SECURITY
NUMBER (cont'd)**

§576D-13(j), HRS requires the social security number of any applicant for a professional license or occupational license be recorded on the application for license; and **§436B-10(4)** HRS which states that an applicant for license shall provide the applicant's social security number if the licensing authority is authorized by federal law to require the disclosure (and by the federal cites shown above, we are authorized to require the social security number).

ADDRESS OF BOARD

Mail all required items to:

BOARD OF PHARMACY
DCCA, PVL LICENSING BR
P.O. Box 3469
Honolulu, HI 96801

or Deliver to office location at:

335 Merchant St., Room 301
Honolulu, HI 96813
Ph. No. (808) 586-3000

CHANGES

Any change in the application or of any information filed with the Board of Pharmacy, shall be reported to the Board in writing within ten (10) days of the change.

RELOCATION

If the pharmacy relocates to another address, the following must be submitted: 1) written notification that the pharmacy has moved from (old address) to (new address); 2) original written verification from the pharmacy's home state indicating the new pharmacy address; and 3) \$10 reissue of license fee.

BIENNIAL RENEWAL

All licenses, regardless of issuance date, are subject to renewal on or before December 31, of each ODD-NUMBERED year.

The failure to timely renew a license, including payment of fees shall cause the license to be automatically forfeited. A license which has been forfeited may be restored within three (3) years after the date of forfeiture upon compliance with the licensing renewal requirements. After 3 years, a new application for license shall be required.

**ABANDONMENT
OF APPLICATION**

Pursuant to HRS §436B-9 your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for two consecutive years. The failure to provide evidence of continued efforts includes but is not limited to: (1) failure to submit any required information and documents requested by the licensing authority within two consecutive years from the last date the documents and information were requested, or (2) failure to complete any additional requirements for licensure that remain after approval of you application, such as attempting to complete an exam requirement, within two consecutive years from the date your application was approved, or (3) failure to provide the licensing authority with any written communication during two consecutive years indicating that you are attempting to complete the licensing process. If an application is deemed abandoned the applicant shall be required to reapply for licensure and comply with the licensing requirements in effect at the time of the reapplication.

**BOARD OF PHARMACY
APPLICATION FOR MISCELLANEOUS PERMIT**

Type or print legibly in dark ink.

PMP Checkout

- Fees: \$295 / \$185 PHY verification
 BREGS (in state only) PH verification
 Statement

Eff. Date:	Permit No.: PMP-
------------	---------------------

FOR OFFICE USE

Applicant (Name of corporation, partnership, LLC or LLP, if individual, First, Middle, Last):

Trade Name (if one will be used):

Location (include suite no., city, state & zip code):

Mailing Address (only if different from location):	Fax No.
--	---------

Social Security No.	Contact Person
---------------------	----------------

Business Phone No.	Toll Free No.
--------------------	---------------

Check the type of application being made:

NEW PERMIT. Business NOT owned by anyone else before.

NEW PERMIT. Business formerly owned by someone else.
(Attach letter of sale.)
Name of former owner & trade name:

dba _____

License number of former owner _____

E-Mail Address	Web Site Address
----------------	------------------

Check type of business entity:

SOLE OWNER LIMITED LIABILITY PARTNERSHIP
 CORPORATION LIMITED LIABILITY COMPANY
 PARTNERSHIP

CHECK BUSINESS INTENDED:

- Sale of any prescription drug at public auction or sale of any prescription drug at private sale in a place where public auctions are conducted.
- Distribution or dispensing of any prescription drug samples to other than physicians, druggists, dentists, veterinarians and optometrists for use in their professional practice.
- For wholesalers to sell, distribute or dispense any prescription drug to other than pharmacists, physicians, dentists, veterinarians or optometrists.
- For any wholesale prescription drug distributor to sell or distribute medical oxygen to a physician, pharmacist, medical oxygen distributor, patient or patient's agent pursuant to a prescription or emergency medical services for administration by trained personnel for oxygen deficiency and resuscitation.
- For any medical oxygen distributor to supply medical oxygen pursuant to a prescription order.
- For any person, as principal or agent to conduct or engage in the business of preparing, manufacturing, compounding, packing or repacking any drug.
- For any out-of-state pharmacy or entity engaging in the practice of pharmacy, in any manner to distribute, ship, mail or deliver prescription drugs or devices into the State.

Circle answers: (All questions pertain to the applicant, officers, partners, members and pharmacist(s))

- In the past twenty years have you ever been convicted of a crime in which the conviction has not been annulled or expunged? YES NO
(If "yes" response provide information on the date, place and type of conviction on a separate sheet, including supporting official documentation)
- Are you a U.S. citizen, U.S. National or alien authorized to work in the United States? YES NO
- Has the applicant or any personnel of the applicant been found in violation of any state or federal drug laws including the illegal use of drugs or improper distribution of drugs? YES NO
(Explain any "yes" answers on a separate sheet and including official supporting documentation.)

This material can be made available for individuals with special needs.
Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

App.....	496	\$100
LIC.....	499	\$ 50
CRF	497	\$35/\$70
½ Ren.....	490	\$ 75
Service charge.....	BCF	\$ 25

Name of Applicant: _____

RESIDENCE ADDRESSES	Name	Social Security No.	Residence Address	Phone No.
	Sole Owner			
	President, Partner, Director, Manager or Member			
	Vice-President, Partner, Director, Manager or Member			
	Secretary, Partner, Director, Manager or Member			
	Treasurer, Partner, Director, Manager or Member			

OUT-OF-STATE PHARMACY OR ENTITY APPLICANT ONLY	List the state in which your pharmacy is located _____
	Is this pharmacy licensed in the state in which it is domiciled? (home state) YES NO
	Have you attached official verification (original with seal) from the state regulatory agency or Board of Pharmacy of the home state of a valid, unexpired, unencumbered license, permit, or registration to conduct the pharmacy in compliance with the laws of the home state? YES NO <i>(Attached form may be used.)</i>
	List the name(s) and license number(s) of the registered pharmacist(s) employed and licensed in the state in which your pharmacy is domiciled. _____
	Have you attached official verification (original with seal) from the state regulatory agency or Board of Pharmacy of the home state that the licenses of your pharmacist(s) are current and unencumbered? YES NO <i>(Attached form may be used.)</i>

Explain any "NO" responses on a separate sheet.

Affidavit of out-of-state pharmacy or entity applicant:

I certify that I and any personnel of mine responsible for any prescriptions for Hawaii residents have not been found in violation of any state or federal drug laws, including the illegal use of drugs or improper distribution of drugs and that I agree to maintain a valid, unexpired, unencumbered license, permit or registration to conduct the pharmacy in compliance with the laws of the state in which the pharmacy is located as well as agree to employ pharmacists licensed in the state in which the pharmacy is located.

I further certify that the statements, answers and representations made in this application and the documents attached are true and correct. I understand that any misrepresentation is grounds for refusal or subsequent revocation of license and is a misdemeanor (*Section 710-1017, Sections 436B-19 and 461-21, Hawaii Revised Statutes*).

Date

Signature of Applicant

Its _____
(Title)

(Print name of person signing)

Affidavit of all other applicants:

I certify that the statements, answers and representations made in this application and the documents attached are true and correct. I understand that any misrepresentation is grounds for refusal or subsequent revocation of license and is a misdemeanor (*Section 710-1017, Sections 436B-19 and 461-21, Hawaii Revised Statutes*).

Date

Signature of Applicant

Its _____
(Title)

(Print name of person signing)

VERIFICATION OF LICENSE – PHARMACIST

Access this form via website at: www.hawaii.gov/dcca/areas/pvl

TO BE COMPLETED BY APPLICANT:

APPLICANT	Name (First, Middle)	(LAST)	Social Security No.
	Address (Include Apt. No., City, State and Zip Code)		License No.
			Date Issued
<p>I hereby authorize the licensing agency of the state of _____ to furnish the information below to the State of Hawaii Board of Pharmacy.</p> <p>Date _____ SIGN HERE _____</p>			

TO BE COMPLETED BY LICENSING AGENCY:

LICENSING AGENCY	<p>This is to certify that the above-named individual was issued license number _____ to practice as a pharmacist.</p> <p>Date issued: _____</p> <p>Date license/certificate expires: _____</p> <p>License status: <input type="checkbox"/> current <input type="checkbox"/> lapsed since: _____ <input type="checkbox"/> inactive since: _____</p> <p>Has this certificate ever been encumbered in any way (revoked, suspended, surrendered, limited, placed on probation, currently pending disciplinary action, being investigated)? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(Please explain yes response and attach copy of board's order and related information.)</i></p> <p>Do you files contain any derogatory information on this applicant? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(Please explain yes response and attach copy of board's order and related information.)</i></p> <p>COMMENTS:</p>		
	<p>Signature: _____</p> <p>Title: _____</p> <p>State: _____</p> <p>Date: _____</p>		
	BOARD SEAL		
	<p><i>TO THE APPLICANT: Attach original with board's seal to your application form.</i></p>		

VERIFICATION OF LICENSE – PHARMACY

Access this form via website at: www.hawaii.gov/dcca/areas/pvl

Hawaii Board of Pharmacy
 DCCA, PVL Licensing Branch
 P.O. Box 3469
 Honolulu, HI 96801

TO BE COMPLETED BY APPLICANT:

APPLICANT	Name of corporation, partnership, LLC, OR LLP; if individual, First, Middle, Last; include trade name if used:	Social Security No. (if individual)
	Location (Include apt. or suite no., city, state and zip code)	License Number
	Mailing address (if different from location):	Date Issued
I hereby authorize the licensing agency of the state of _____ to furnish the information below to the State of Hawaii Board of Pharmacy.		
Date _____ SIGN HERE _____ TITLE _____		

TO BE COMPLETED BY LICENSING AGENCY:

LICENSING AGENCY	This is to certify that the above-named entity or individual was issued license number _____ to operate as a pharmacy:	
	Date issued: _____	
	Date license/certificate expires: _____	
	License status:	<input type="checkbox"/> current <input type="checkbox"/> lapsed since: _____ <input type="checkbox"/> inactive since: _____
	Has this certificate ever been encumbered in any way (revoked, suspended, surrendered, limited, placed on probation, currently pending disciplinary action, being investigated)? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(Please explain yes response and attach copy of board's order and related information.)</i>	
Do your files contain any derogatory information on this applicant? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(Please explain yes response and attach copy of board's order and related information.)</i>		
COMMENTS:		
Signature: _____ Title: _____ State: _____ Date: _____	BOARD SEAL	
TO THE APPLICANT: <i>Attach original, with board's seal, to your application form.</i>		