



# MAINE BOARD OF PHARMACY

Application information to assist  
in completing your application. This information is not designed to include all information on  
laws and rules and it is strongly recommended that you review applicable laws and rules.

## Pharmacy Change of Pharmacist in Charge For A Licensed Pharmacy Located in the State of Maine

Do not return the following informational pages with your  
application; it is for your information only

Department of Professional and Financial Regulation  
Office of Professional and Occupational Regulation  
(Mailing address) 35 State House Station, Augusta, ME 04333  
(Office location) Gardiner Annex, 76 Northern Avenue, Gardiner, Maine 04345

Office Direct Line (207) 624-8620 or Main Receptionist (207) 624-8603  
TTY users call Maine relay 711  
FAX (207) 624-8637

Web address: [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing)  
Email: [pharmacy.lic@maine.gov](mailto:pharmacy.lic@maine.gov)

### FAQ's

Have a question? Please visit our list of Frequently Asked Questions

### Can I come to Gardiner to drop off my application?

No, the Gardiner Annex is closed to the public until further notice due to the Covid-19  
pandemic. Please mail your paper application to our mailing address  
35 State House Station, Augusta, ME 04333.



**STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION  
COMPANY APPLICATION**

|                                                                 |       |              |        |
|-----------------------------------------------------------------|-------|--------------|--------|
| APPLICANT INFORMATION (please print)                            |       |              |        |
| NAME OF PHARMACY                                                |       |              |        |
| FEIN OR SSN                                                     |       |              |        |
| PHYSICAL LOCATION OF THE PHARMACY                               |       |              |        |
| CITY                                                            | STATE | ZIP          | COUNTY |
| CONTACT ADDRESS                                                 |       |              |        |
| CITY                                                            | STATE | ZIP          | COUNTY |
| PHONE # (    )                                                  |       | FAX # (    ) |        |
| PERSON RESPONSIBLE FOR<br>COMPLETING AND SUBMITTING APPLICATION |       |              |        |

**Maine Board of Pharmacy**  
**Change of Pharmacist in Charge**  
for a Licensed Pharmacy Located in the State of Maine  
**No Fee**

Maine Pharmacy License #

PH \_\_\_\_\_

Expiration Date \_\_\_\_\_

**SECTION 1: COMPANY INFORMATION**

|                                                   |                     |
|---------------------------------------------------|---------------------|
| Name of Pharmacy                                  |                     |
|                                                   |                     |
| Pharmacy Telephone Number                         | Pharmacy Fax Number |
| (      )                                          | (      )            |
| E-mail Address                                    |                     |
|                                                   |                     |
| Web Address                                       | DEA #               |
|                                                   |                     |
| All Trade Names or Business Names of the Pharmacy |                     |
|                                                   |                     |

**SECTION 2: PHARMACIST IN CHARGE INFORMATION** (32 MRSA §13702-A (23)) “Pharmacist in charge means the pharmacist who is responsible for the licensing of the pharmacy,”  
**THE MAINE BOARD OF PHARMACY HOLDS THE PIC RESPONSIBLE FOR ALL PHARMACY RELATED MATTERS.**

|                           |      |                 |          |
|---------------------------|------|-----------------|----------|
| Pharmacist in Charge Name |      |                 |          |
|                           |      |                 |          |
| Pharmacist License Number |      | Expiration Date |          |
|                           |      |                 |          |
| Contact Address of PIC    | City | State           | Zip Code |
|                           |      |                 |          |
| E-mail Address            |      |                 |          |
|                           |      |                 |          |

**SECTION 3: EFFECTIVE DATE OF CHANGE**

|                                                                     |
|---------------------------------------------------------------------|
| Effective date you, the pharmacist in charge, will take over as PIC |
|                                                                     |
| Name of Pharmacist In Charge you are replacing:                     |

**SECTION 4: PHARMACY TECHNICIAN REPORT** (Ref. Board Rules, Chapter 7, Section 3(3))

Please list all pharmacy technicians\* employed at the pharmacy. (Use separate sheet if necessary)

\*This applies to pharmacy technicians who are properly registered with the Maine Board of Pharmacy as Pharmacy Technician. Please make extra copies of the page for additional employees.

|                               |                |                 |
|-------------------------------|----------------|-----------------|
| 1. Pharmacy Technician's Name | License Number | Expiration Date |
|                               |                |                 |
| 2. Pharmacy Technician's Name | License Number | Expiration Date |
|                               |                |                 |
| 3. Pharmacy Technician's Name | License Number | Expiration Date |
|                               |                |                 |
| 4. Pharmacy Technician's Name | License Number | Expiration Date |
|                               |                |                 |
| 5. Pharmacy Technician's Name | License Number | Expiration Date |
|                               |                |                 |
| 6. Pharmacy Technician's Name | License Number | Expiration Date |
|                               |                |                 |

**SECTION 5: DESIGNATION OF AUTHORIZED PERSONS** (See Ref. Board Rule, Ch. 1, Sec. 1)

|                 |       |                    |               |
|-----------------|-------|--------------------|---------------|
| 1. First Name   | MI    | Last Name          | Date of Birth |
|                 |       |                    |               |
| Contact Address |       | Street or P.O. Box |               |
|                 |       |                    |               |
| City            | State | Zip Code           | County        |
|                 |       |                    |               |
| Position Title  |       | Purpose            |               |
|                 |       |                    |               |
| 2. First Name   | MI    | Last Name          | Date of Birth |
|                 |       |                    |               |
| Contact Address |       | Street or P.O. Box |               |
|                 |       |                    |               |
| City            | State | Zip Code           | County        |
|                 |       |                    |               |
| Position Title  |       | Purpose            |               |
|                 |       |                    |               |

**SECTION 6: THIS SECTION APPLIES ONLY TO WAIVER REQUEST(S) (requirements listed in Board Rules Chapter 8 sec. 2):**

Please check all that apply and attached a letter to demonstrate good cause for waiver requested.

- ☐ Minimum 40 hours per week of operation
- ☐ Practice by the pharmacist in charge at the drug outlet for which he or she has registered for a minimum of 30 hours per week or 50% of the hours that the pharmacy is open, whichever is less.

**SECTION 7: NOTICES**

**Please Note:**

Pursuant to 10 MRS §8003-G - any change in name, address, email address, criminal convictions, disciplinary actions, or any material change set forth in your original application for licensure must be reported to the Office within 10 days.

You can access this Law for your review at:

<http://www.mainelegislature.org/legis/statutes/10/title10ch901sec0.html>

## SECTION 8: PHARMACIST IN CHARGE INFORMATION

Check appropriate response to the questions below. Any YES response must be fully explained by written statement on a separate sheet of paper, signed and dated, and submitted with your application.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| Have you, the pharmacist in charge, <b>ever</b> been denied registration by the U.S. Drug Enforcement Administration (DEA) or have you ever had a DEA Registration modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked your state permit to prescribe or dispense controlled substances? If yes:<br><br>1. <input type="checkbox"/> DEA action<br><input type="checkbox"/> Other State of Province (Name) _____<br>2. Submit a copy of the official action by the entity.<br>3. Provide a detailed explanation in your own words on a separate sheet of paper.                                                                                                                                                                                                                                               | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Have you, the Pharmacist in Charge, <b>ever</b> received a sanction from Medicare or from a state Medicaid program?<br><br>1. Medicare OR Medicaid Program (State) _____<br>2. Submit a copy of the official action by the entity.<br>3. Provide a detailed explanation in your own words on a separate sheet of paper.<br><br>Clarification on programs:<br><ul style="list-style-type: none"><li>• Medicare – Health program administered by the United States government for people that are (1) ages 65 or older, (2) under the age of 65 with certain disabilities, and/or (3) all ages with end-stage renal disease.</li><li>• Medicaid – Health program administered by the United States government for people with limited incomes.</li><li>• MaineCare – Health program administered by the State of Maine with similar eligibility requirements as Medicaid.</li></ul> | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Has any jurisdiction <b>ever</b> taken disciplinary action against any professional license you, the Pharmacist in Charge, hold or have held, or denied your application for licensure? If yes, enclose a detailed explanation and copies of consent agreement or board order.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Has this entity <b>ever</b> been issued a citation, warning letter or untitled letter by FDA or similar action take by any governmental board?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |

## SECTION 9: LAWS AND RULES REFERENCE

Information contained in this application is not a substitute for carefully reviewing applicable laws and rules. You may obtain a copy of the laws and board rules online at [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing)—Click on “list of licensed professionals”, click on “Pharmacy” under “Board of Pharmacy Home” click on “Laws & Rules” You may also contact the following agency for federal regulations: U.S. Government Printing Office Tel (202) 512-1800, at the following web site: [www.access.gpo.gov/nara/cfr/cfr-table-search.html](http://www.access.gpo.gov/nara/cfr/cfr-table-search.html)

Notwithstanding, please pay particular attention to the following:

- 32 MRSA Chapter 117, Subchapter 5
- Board Rules, Chapter 8 & 13

**DID YOU ENCLOSE THE FOLLOWING:**

*Please review the list below to ensure you are filing a complete application. If the application is not yet complete, please wait until you have all of the required documentation to submit with this application.*

- ◇ Each section of the application is completed.
- ◇ Signature present where noted.
- ◇ A signed copy of the consent agreement or order issued by the Board/Jurisdiction if discipline has been indicated.

**◇ SECTION 10: SIGNATURE AND AFFIRMATION**

Read the statement below and sign where indicated as your certification of the information provided on this application.

As the Pharmacist in Charge I acknowledge and certify by my signature that I have read, understand, and will abide by 32 MRS Chapter 117 of the Maine Pharmacy Act and the related Laws and Rules. I also acknowledge my duties and responsibilities to the management and operation of the pharmacy named in this application in all matters directly or indirectly related to the practice of pharmacy including, but not limited to, any matters related to the health, welfare, and the safety of the public.

By submitting this completed form, I understand that the Maine Board of Pharmacy will rely upon this information as being truthful and factual and that sanctions may be imposed, including denial, suspension or revocation of the pharmacy license and/or my pharmacist license, if this information is found to be false.

|                                                                                     |                |
|-------------------------------------------------------------------------------------|----------------|
| Pharmacist in Charge Name (print legibly)                                           | License number |
|                                                                                     |                |
| Signature of Licensed Pharmacist in Charge                                          | Date           |
|  |                |