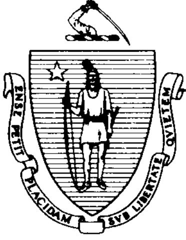


The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure

Board of Registration in Pharmacy
239 Causeway Street, Suite 500, 5th Floor
Boston, MA 02114
http://www.mass.gov/dph/boards/ph
PH (617) 973-0960 FAX (617) 973-0980 TTY (617) 973-0895

APPLICATION FOR TRANSFER OF OWNERSHIP OF A PHARMACY.

Whenever there is to be a transfer of ownership of a pharmacy or pharmacy department or if the pharmacy or pharmacy department is to be owned by a person or entity other than the person or entity who was listed on the initial application for registration to manage and operate a pharmacy or pharmacy department, an application for transfer of ownership shall be obtained from, and submitted to, the Board. A completed application shall:

(a) Meet all the requirements of 247 CMR 6.03(1), if there is a change of pharmacist Manager of Record;

(b) state the full name of the new owner;

(c) have attached thereto an official bill of sale or minutes of meeting; including a certified copy of asset transfer;

(d) if the new owner is a corporation:

1. have attached thereto a copy of the corporation's Articles of Organization, signed and sealed by the Secretary of State, if the corporation is incorporated in the Commonwealth;

2. have attached thereto a copy of the corporation's Foreign Corporation Certificate, signed and sealed by the Secretary of State pursuant to M.G.L. c. 181, § 4, if the corporation in incorporated in another state;

3. indicate the name and address of each officer and director of the corporation and the position held;

4. indicate the d/b/a name of the corporation; and

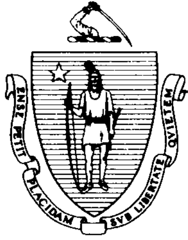
5. if the corporation is not publicly owned, indicate the total amount and type of stock issued to each stockholder and the names and addresses of said stockholder(s).

6. the outstanding permit, Massachusetts controlled substances registration, and certificate of fitness, if any

7. a check or money order made payable, in the proper amount to the Commonwealth of Massachusetts.

8. **The Self-Inspection Form (available on the Board's website) should be completed by a Pharmacist within 30 days of submitting an APPLICATION FOR TRANSFER OF OWNERSHIP to the Board for a Pharmacy/Pharmacy Department.**

In order to obtain a DEA number, please contact the Drug Enforcement Administration (DEA) office for an application. DEA's address is: J.F.K. Federal Building, Drug Enforcement Administration, 15 New Sudbury Court, Room E 400, Boston, MA, 02203-0131 (617) 557-2200



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APPLICATION FOR TRANSFER OF OWNERSHIP OF COMMUNITY PHARMACY

I hereby apply for a permit to operate a store for the transaction of retail drug business in accordance with the provisions of Chapter 112, General Laws.

$525.00 licensure / application fee. Make check or money order payable to the *Commonwealth of Massachusetts*. **This fee is non-refundable.**

1. Legal Name of Business.____
2. Full Business Address (Street Address, City, State and Zip).___________________________________
   ____
3. Area Code and Telephone Number.____
   ____
4. All trade or business names ("D.B.A." names) used by same Corporation or by Licensee.
   ____
5. Email address for this Pharmacy:____
6. Type of ownership or operation (i.e., sole proprietorship, partnership, corporate distribution center for multi-unit (chain) pharmacy corporation).____
   ____
   If corporation, please submit articles of corporation.
7. Name(s) and Social Security Number(s) of the proposed new owner(s) and/or operator(s) of the licensee. *Please indicate type of ownership-Partnerships: the name of each partner and name and address of partnership; Corporations: the name and title of each corporate officer and director, the corporate names, name and address of parent company, if any, and the State of incorporation's;* Sole Proprietorships: the name of the sole proprietor and the name and address of the business entity. ____
   ____

8. Name of registered pharmacist previously charged with the management of the pharmacy.
____

9. Registration number of previous manager.____________________________________

10. Name of registered pharmacist who is applying to manage the pharmacy.________________
____

11. Registration number of applying pharmacy manager._____________________________
____

12. Name(s) and registration number(s) of staff pharmacist(s) employed at pharmacy.___________
____
____
____

13. Have any of the applicant(s) and/or managers-in-charge had: 1) any convictions related to the distribution of drugs (including samples); 2) any felony convictions; 3) any suspension(s) or revocation(s) or other sanction(s) by federal, state or local governmental agency of any license or registration currently or previously held by the applicant or licensee for the manufacture, distribution, or dispensing of any drugs, including controlled substances? Have any applications for licensure been denied by any federal or state agency including any state boards of pharmacy? List and explain. Attach additional sheets if necessary.
____
____
____

14. The applicant / licensee must notify the Board in writing of any changes in ownership or management within thirty (30) days of such change(s).

15. Pursuant to Board Regulations at 247 CMR δ 6.01(3), **The Board shall not register nor permit ownership of a pharmacy or pharmacy department by a practitioner with prescriptive privileges.** By signing this application the applicant certifies that none of the owners, directors or officers have prescriptive privileges.

Affidavit (must be completed and notarized)

Pursuant to M.G.L. c. 62C, s. 49A, I certify under the penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

The applicant certifies that each person employed in any prescription drug distribution activity has the education, training, and experience, or any combination thereof, sufficient for that person to perform the assigned functions in such a manner as to provide assurance that the drug product quality, safety, and security will at all times be maintained as required by law.

WARNING:

In accordance with Chapter 94 M.G.L. Sec 13, the Board of Registration in Pharmacy in the case of a retail drug business or wholesale druggist, may suspend or revoke a registration to manufacture, distribute, dispense or possess a controlled substance after a hearing pursuant to the provisions of Chapter 34A and upon finding that the registrant has furnished false or fraudulent information in any application filed under the provisions of Chapter 94C.

I hereby state that I am the person authorized to sign this application for all licensure.

____ __________

Signature of pharmacist who is to manage the pharmacy or pharmacy department *Date*

____

Social Security Number of managing pharmacist

Sworn and subscribed before me this_______day of __________

Name of Notary Public ___________________________ Date _______

My commission expires_____________________ NOTARY SEAL

RETAIN A COPY OF THIS APPLICATION FOR YOUR RECORDS.

ALL FEES ARE NON-REFUNDABLE AND NON-TRANSFERABLE

TO BE COMPLETED BY BOARD:

Check $__________Date________ Number__________
Receipt No._____________________

MASSACHUSETTS BOARD OF REGISTRATION IN PHARMACY
239 Causeway Street, 5th Floor
Boston, MA 02114
(617) 973-0960
pharmacy.admin@massmail.state.ma.us

Controlled Substance Registration (CSR) Application

(MA Resident pharmacies only)

I hereby apply for a Controlled Substances Registration in accordance with M.G.L. c. 94C, § 7.

Name of Corporation/Applicant ____

Street Address ____

City/Town ______________________________ State__________ Zip Code ___________

Tel. No. _________________________ Fax No. ___________________________

E-mail____

FEIN Number: ______________________

Registration Classification:

☐ Drug Store Pharmacy

☐ Complex Non-Sterile Compounding Pharmacy ☐ Sterile Compounding Pharmacy

Please check applicable controlled substance(s):

☐Schedule II ☐Schedule III ☐Schedule IV ☐Schedule V ☐Schedule VI**

**** Schedule VI: This substance is a prescription drug that has not already been included in Schedules II-V.**

Signature of Applicant: ____
(Owner of facility must sign application)

Printed Name of Applicant whose signature appears above: ___________________________

TO BE COMPLETED BY BOARD

CHECK $______________DATE____________

CHECK NO.___________RECEIPT NO.____________________APP NO.____________

LICENSE NO.__________________/______________________

___________________________/_____________________/__________________