

State of Florida
Department of Business and Professional Regulation
Division of Drugs, Devices, and Cosmetics

Application for Permit as a Prescription Drug Wholesale Distributor
Form No.: DBPR-DDC-213

APPLICATION CHECKLIST – IMPORTANT – Submit all items on the checklist below with your application to ensure faster processing.

APPLICATION	APPLICATION REQUIREMENTS
<p>Application for Permit as a Prescription Drug Wholesale Distributor</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Initial Permit. Fee of \$1,750.00, which includes a <u>nonrefundable</u> \$1,600.00 biennial permitting fee and \$150.00 initial application/on-site inspection fee. <input type="checkbox"/> Permit Renewal. Fee of \$1,600.00, which includes a <u>nonrefundable</u> \$1,600.00 biennial permitting fee. To avoid a \$100 delinquent fee, your renewal must be postmarked 45 days prior to the permit's expiration date. <input type="checkbox"/> Make cashier's check, corporate check, or money order payable to the Florida Department of Business and Professional Regulation or DBPR. <input type="checkbox"/> If you answer "Yes" to any question in Section IV, be sure to provide a detailed explanation along with any relevant documentation. <input type="checkbox"/> Sign and date the Affidavit section of the application.
	<p>Mail completed application to: Department of Business and Professional Regulation 2601 Blair Stone Road Tallahassee, FL 32399-1047</p>

PLEASE NOTE:

- Telephone, email, and fax contact information is used to quickly resolve questions with applications. If such information is not provided, questions regarding applications will be mailed to the application contact's mailing address and may take longer to resolve.
- The disclosure of Social Security numbers is mandatory on all professional and occupational license applications, is solicited by the authority granted by 42 U.S.C. §§ 653 and 654, and will be used by the Department of Business and Professional Regulation pursuant to §§ 409.2577, 409.2598, 499.012(4)(a)f, 499.012(8)(o), 499.63(2), and 559.79(3), Florida Statutes, for the efficient screening of applicant and licensees by a Title IV-D child support agency to assure compliance with child support obligations. It is also required by § 559.79(1), Florida Statutes, for determining eligibility for licensure and mandated by the authority granted by 42 U.S.C. § 405(c)(2)(C)(i), to be used by the Department of Business and Professional Regulation to identify licensees for tax administration purposes.

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If you have any questions or need assistance in completing this application, please contact the Department of Business and Professional Regulation, Division of Drugs, Devices and Cosmetics, at **850.717.1800**. **For additional information see the instructions at the beginning of this application.**

Section I – Application Type

TYPE OF APPLICATION
Please indicate whether this is a new permit application or a permit renewal application?
<p><input type="checkbox"/> New Application [1021].</p> <p><input type="checkbox"/> New Application – Change in Ownership or Control [1021]. A new permit is required for a change in ownership or controlling interest. <u>Once a change of ownership occurs, you are prohibited from distributing under the prior permit.</u> You may not distribute prescription drugs in, into or from Florida until a new permit has been issued. If this application is being filed due to a change in ownership, please provide:</p> <p>a. Prior Permit Number: _____ Name of Prior Owner(s): _____</p> <p>b. Legal documentation of the change in ownership or control, for example, a stock purchase agreement or an executed contract for sale, etc.</p> <p>If this application is being filed because there has been (or there will be in the immediate future) a change in the ownership or controlling interest in the establishment, please provide documentation of the change in ownership or control. If the change has not occurred, but is imminent, please check the appropriate box and indicate the date that the change of ownership or control will take place.</p> <p><input type="checkbox"/> The change in ownership or control became effective on ___/___/___ and documentation (IS <input type="checkbox"/>) or (IS NOT <input type="checkbox"/>) included.</p> <p><input type="checkbox"/> The change in ownership or control is expected to become effective on ___/___/___ and documentation thereof will be provided to the division within 30 days of the effective date. <u>I understand that the application is incomplete until documentation of the change in ownership or control is received by the division.</u></p> <p><input type="checkbox"/> Renewal Application [2020]. NOTE: To avoid the \$100 delinquent fee, your renewal must be postmarked 45 days prior to the permit's expiration date.</p> <p>Current Permit Number: _____ Current Expiration Date: _____</p>
Please indicate the type of wholesale distributor permit that is being sought:
<p><input type="checkbox"/> Prescription Drug Wholesale Distributor [3322] – (Physically located in Florida)</p> <p><input type="checkbox"/> Prescription Drug Wholesale Distributor – Broker Only [3329] – (Physically located in Florida, but does not take physical possession of prescription drugs)</p>

Section II – Applicant Information

APPLICANT INFORMATION		
TAXPAYER IDENTIFICATION NUMBER OR FEDERAL EMPLOYER IDENTIFICATION NUMBER		
<p>This is a unique nine-digit number assigned by the Internal Revenue Service (IRS) to business entities operating in the United States for the purposes of identification. When the number is used for identification rather than employment tax reporting, it is usually referred to as a Taxpayer Identification Number (TIN), and when used for the purposes of reporting employment taxes, it is usually referred to as the Federal Employer Identification Number (FEIN).</p>		
Applicant's TIN/FEIN:		
FULL LEGAL NAME		
<p>The "full legal name" is the complete name of the business entity that will be operating the establishment. This is generally the name that is on the documents that establish the existence or formation of the business entity. For example, a corporation's full legal name would normally be the name that is found in the corporation's articles of incorporation.</p>		
Applicant's Full Legal Name:		
FICTITIOUS, TRADE, OR BUSINESS NAME		
<p>If the applicant intends to operate the permitted establishment under a name that is different from the Applicant's Full Legal Name listed above – e.g. fictitious, trade, or business name (also commonly referred to as a "dba", "D/B/A", or "doing business as" name – this name must be registered with the Florida Department of State, Division of Corporations. This is the name that will appear on the permit issued to the applicant by the department and must be the name that the applicant uses on operational documents for permitted activities.</p>		
<input type="checkbox"/> The applicant WILL NOT operate the permitted establishment under a name that is different from the Applicant's Full Legal Name listed above.		
<input type="checkbox"/> The applicant WILL operate the permitted establishment under the following fictitious, trade, or business name:		

<p>The fictitious, trade, or business name listed directly above, is registered with the Florida Department of State, Division of Corporations and the applicant has been issued the following registration number:</p>		
_____.		
APPLICANT MAILING ADDRESS		
Street Address or P.O. Box:		
City:	State:	Zip Code (+4 optional):
E-Mail Address:	Telephone Number:	Fax Number:
PHYSICAL ADDRESS OF ESTABLISHMENT TO BE PERMITTED (only if different from mailing address) Check <input type="checkbox"/> if not applicable		
Street Address:		
City:	State:	Zip Code (+4 optional):

E-Mail Address:		Telephone Number:	Fax Number:
APPLICATION CONTACT			
The application contact is the person that the department will contact if there are questions regarding the responses provided on, or the documentation submitted with, the application. The application contact is also the person that will receive all official communication from the department regarding the application.			
Last/Surname:	First:	Middle:	Suffix:
Address:			
City:	State:	Zip Code (+4 optional):	
E-Mail Address:	Telephone Number:	Fax Number:	
EMERGENCY CONTACT INFORMATION			
The emergency contact is the person that the department will contact in the case of an emergency. During an emergency, the department will contact this person at times outside of the normal business hours listed below. The contact information provided should be sufficient for the department to actually reach and communicate with the person listed in the event of an emergency.			
Last/Surname:	First:	Middle:	Suffix:
Position/Title:			
Street Address:			
City:	State:	Zip Code (+4 optional):	
E-Mail Address:	Telephone Number:	Fax Number:	

BUSINESS HOURS	
NORMAL BUSINESS HOURS	
Normal business hours are those hours, Monday through Friday, between 8:00 a.m. and 5:00 p.m. Eastern Time, during which the establishment and the establishment's onsite management and or administrative office, if either are present, conducts regular business activities.	
List the establishment's daily normal business hours in terms of Eastern Time. REMEMBER to circle "a.m." or "p.m." for each time indicated below.	
Mon ____:____ a.m./p.m. to ____:____ a.m./p.m.	Thu ____:____ a.m./p.m. to ____:____ a.m./p.m.
Tue ____:____ a.m./p.m. to ____:____ a.m./p.m.	Fri ____:____ a.m./p.m. to ____:____ a.m./p.m.
Wed ____:____ a.m./p.m. to ____:____ a.m./p.m.	

OPERATING HOURS

Operating hours are those hours, Sunday through Saturday, between 12:00 a.m. and 11:59 p.m. Eastern Time, during which the establishment conducts regular business activities (including but not limited to picking for orders and stocking inventory). The operating hours **include** the establishment's normal business hours **and** those hours outside of normal business hours where the establishment and the establishment's onsite management and or administrative office, if either is present, are not open to the public or its customers.

List the establishment's daily hours operating hours in terms of Eastern Time. REMEMBER to circle "a.m." or "p.m." for each time indicated below.

Sun ____:____ a.m./p.m. to ____:____ a.m./p.m.	Thu ____:____ a.m./p.m. to ____:____ a.m./p.m.
Mon ____:____ a.m./p.m. to ____:____ a.m./p.m.	Fri ____:____ a.m./p.m. to ____:____ a.m./p.m.
Tue ____:____ a.m./p.m. to ____:____ a.m./p.m.	Sat ____:____ a.m./p.m. to ____:____ a.m./p.m.
Wed ____:____ a.m./p.m. to ____:____ a.m./p.m.	

Section III – Ownership Information

TYPE OF OWNERSHIP

- | | | |
|---|--|---|
| <input type="checkbox"/> Publicly Held Corporation | <input type="checkbox"/> Closely Held Corporation | <input type="checkbox"/> Limited Liability Company |
| <input type="checkbox"/> Charitable Organization—501(c)(3) | <input type="checkbox"/> Sole Proprietorship | <input type="checkbox"/> Government |
| <input type="checkbox"/> Partnership – General | <input type="checkbox"/> Professional Corporation or Association | <input type="checkbox"/> Professional Limited Liability Company |
| <input type="checkbox"/> Partnership – Other, Including Limited Liability Partnership and Limited Partnership | <input type="checkbox"/> Other: _____ | |

List the state of incorporation or state of organization (except Partnership – General or Sole Proprietorship). Business entities organized under non-U.S. laws list the country of organization.

N/A (Partnership – General or Sole Proprietorship)

State:

List name and address of the applicant's registered agent for service of process in Florida (except Sole Proprietorship or Partnership – General) and provide documentation, such as a print out from the Florida Department of State, Division of Corporations' webpage, that the applicant's registered agent is registered with the Florida Department of State, Division of Corporations.

N/A (Partnership – General or Sole Proprietorship)

Name:

Address:

City:

State:

Zip Code (+4 Optional):

List the name, position/title, social security number, date of birth and address of each owner, partner, member, manager, officer, director, chief executive, or other person who directly or indirectly controls the operation of the business entity, as applicable. For example, corporations would list officers and directors, limited liability companies would list members and managers, etc.

1.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
2.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
3.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
4.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
5.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
6.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
7.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
8.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:

List the name, social security number, date of birth and address of each person who owns 5 percent or more of the outstanding stock or equity interest in the business entity. If such person is a business entity, list the business entity name, TIN/FEIN and percentage of ownership and check the box labeled "N/A" for date of birth.

1.	Name:	SSN/TIN/FEIN#	Date of Birth: <input type="checkbox"/> N/A	% of Ownership:
	Street Address:	City:	State:	Zip Code:
2.	Name:	SSN/TIN/FEIN#	Date of Birth: <input type="checkbox"/> N/A	% of Ownership:
	Street Address:	City:	State:	Zip Code:
3.	Name:	SSN/TIN/FEIN#	Date of Birth: <input type="checkbox"/> N/A	% of Ownership:
	Street Address:	City:	State:	Zip Code:
4.	Name:	SSN/TIN/FEIN#	Date of Birth: <input type="checkbox"/> N/A	% of Ownership:
	Street Address:	City:	State:	Zip Code:
5.	Name:	SSN/TIN/FEIN#	Date of Birth: <input type="checkbox"/> N/A	% of Ownership:
	Street Address:	City:	State:	Zip Code:
6.	Name:	SSN/TIN/FEIN#	Date of Birth: <input type="checkbox"/> N/A	% of Ownership:
	Street Address:	City:	State:	Zip Code:
7.	Name:	SSN/TIN/FEIN#	Date of Birth: <input type="checkbox"/> N/A	% of Ownership:
	Street Address:	City:	State:	Zip Code:
8.	Name:	SSN/TIN/FEIN#	Date of Birth: <input type="checkbox"/> N/A	% of Ownership:
	Street Address:	City:	State:	Zip Code:

List all trade or business names used by the applicant. Use additional sheet(s) if necessary. If the applicant does not use other trade or business names check this box and write N/A on the lines below.

Is the applicant a subsidiary of another company? (If yes, provide a listing of all parent companies with percentages of ownership, using additional sheet(s) if necessary). Yes No
Note: A permit issued pursuant to this application is only valid for the applicant, and the applicant's name and address. (If no, please check this box and write "N/A" in the lines below).

Parent Company Name	% of Ownership

Is diagnostic, medical, surgical, or dental treatment or care, or chronic or rehabilitative care services provided at the address of the establishment that is the subject of this permit application? If so, please list the name of the company/companies providing such services below and provide the corresponding license or permit number(s) issued by the State of Florida and/or federal government. (Use additional sheet(s) if necessary). Yes No

Name:	Permit/License No.:	Issuing Agency:

APPLICANT'S AFFILIATES

List the name, TIN/FEIN#, and address (city and state/country) of each affiliate of the applicant below. An "affiliate" is a business entity that has a relationship with another business entity in which, directly or indirectly: (a) the business entity controls, or has the power to control, the other business entity; or (b) a third party controls, or has the power to control, both business entities. (If the applicant has no affiliates, please check this box and write "N/A" in the lines below).

1.	Name: TIN/FEIN#:	City:	State/Country:
2.	Name: TIN/FEIN#:	City:	State/Country:
3.	Name: TIN/FEIN#:	City:	State/Country:
4.	Name: TIN/FEIN#:	City:	State/Country:
5.	Name: TIN/FEIN#:	City:	State/Country:
6.	Name: TIN/FEIN#:	City:	State/Country:

7.	Name: TIN/FEIN#:	City:	State/Country:
8.	Name: TIN/FEIN#:	City:	State/Country:
9.	Name: TIN/FEIN#:	City:	State/Country:
10.	Name: TIN/FEIN#:	City:	State/Country:
11.	Name: TIN/FEIN#:	City:	State/Country:
12.	Name: TIN/FEIN#:	City:	State/Country:
13.	Name: TIN/FEIN#:	City:	State/Country:
14.	Name: TIN/FEIN#:	City:	State/Country:
15.	Name: TIN/FEIN#:	City:	State/Country:

Section IV – Background Questions

BACKGROUND QUESTIONS			
<p>Please answer the questions below. If you are renewing your permit, your answer should be based on information since your previous application submission. If you answer “YES” to any questions in Section IV, you must provide detailed explanations in Section V, including requirements for submitting supporting legal documents. If needed, explain on separate sheet(s).</p> <p>The term “affiliated party” means: (a) a director, officer, trustee, partner, or committee member of a permittee or applicant or a subsidiary or service corporation of the permittee or applicant; (b) a person who, directly or indirectly, manages, controls, or oversees the operation of a permittee or applicant, regardless of whether such person is a partner, shareholder, manager, member, officer, director, independent contractor, or employee of the permittee or applicant; (c) a person who has filed or is required to file a personal information statement pursuant to s. 499.012(9) or is required to be identified in an application for a permit or to renew a permit pursuant to s. 499.012(8); or (d) the five largest natural shareholders that own at least 5 percent of the permittee or applicant.</p>			
1.	<input type="checkbox"/> Yes If yes, explain in detail in Section V	<input type="checkbox"/> No	Has the applicant or any “affiliated party” (defined above) been found guilty of (regardless of adjudication), or pled nolo contendere to, in any jurisdiction, a violation of law that directly relates to a drug, device, or cosmetic?
2.	<input type="checkbox"/> Yes If yes, explain in detail in Section V	<input type="checkbox"/> No	Has the applicant or any affiliated party (defined above) been fined or disciplined by a regulatory agency in any state (including Florida) for any offense that would constitute a violation of Chapter 499, F.S.?
3.	<input type="checkbox"/> Yes If yes, explain in detail in Section V	<input type="checkbox"/> No	Has the applicant or any affiliated party (defined above) been convicted (regardless of adjudication) of any felony under a federal, state (including Florida), or local law?
4.	<input type="checkbox"/> Yes If yes, explain	<input type="checkbox"/> No	Has the applicant or any affiliated party (defined above) been denied a permit or license in any state (including Florida) related to an activity

Section VI – Other Permits or Licenses

PERMITS OR LICENSES		
1.	<p>Are there any permits or licenses issued by any agency of the State of Florida that authorize the purchase or possession of prescription drugs (for example, pharmacy, 3PL, etc.) at the applicant's establishment or address? (If yes, please provide a list of all such permits including the issuing agency, the permit/license type, the permit/license number and the expiration date. If not, check the box indicating no other permits or licenses.).</p> <p style="text-align: right;"> <input type="checkbox"/> Permit/licensure list provided. <input type="checkbox"/> No permits/licenses. </p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	<p>Is diagnostic, medical, surgical, or dental treatment or care, or chronic or rehabilitative care services provided at the address of the establishment that is the subject of this permit application? If so, please list the name of the company/companies providing such services below and provide the corresponding license or permit number(s) issued by your residing state's regulatory authority. (Use additional sheet(s) if necessary).</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	<p>Are there any permits or licenses issued by any other state which authorize the applicant to purchase or possess prescription drugs? (If yes, please provide a list all such permits including the state, the permit/license type, the permit/license name, the permit/license number and the expiration date. If not, check the box indicating no other permits or licenses.).</p> <p style="text-align: right;"> <input type="checkbox"/> Permit/licensure list provided. <input type="checkbox"/> No other permits/licenses. </p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section VII – Prescription Drug Wholesale Distribution Activity

WHOLESALE DISTRIBUTION ACTIVITIES	
<p>Generally identify the applicant's intended customers, the persons and entities that will purchase or receive prescription drugs from the applicant after permit issuance.</p>	
<input type="checkbox"/> Manufacturers <input type="checkbox"/> Hospitals <input type="checkbox"/> Veterinarians <input type="checkbox"/> Other (explain) _____	<input type="checkbox"/> Wholesalers <input type="checkbox"/> Practitioners
<input type="checkbox"/> Pharmacies <input type="checkbox"/> Clinics	
<p>Identify the types of prescription drugs the applicant will distribute under this permit.</p>	
<input type="checkbox"/> Human Prescription Drugs <input type="checkbox"/> Solid Dose <input type="checkbox"/> Liquids (Oral) <input type="checkbox"/> Injectables <input type="checkbox"/> Topical <input type="checkbox"/> Dental <input type="checkbox"/> Ophthalmic <input type="checkbox"/> Compressed Medical Gases	<input type="checkbox"/> Veterinary Prescription Drugs <input type="checkbox"/> Prepackaged / Repackaged medications for physicians (for physician dispensing) <input type="checkbox"/> Repackaged medications for Hospitals or clinics <input type="checkbox"/> Medical Devices containing prescription drugs <input type="checkbox"/> Refrigerated (Human, Veterinary, API or Otherwise) <input type="checkbox"/> Frozen (Human, Veterinary, API or Otherwise)
<input type="checkbox"/> Active Pharmaceutical Ingredients (If yes, check the applicable box(es) for your customers): <input type="checkbox"/> Manufacturers <input type="checkbox"/> Pharmacies for Compounding <input type="checkbox"/> Other explain _____	
<p>Controlled Substances: Provide your DEA Number: _____ or check <input type="checkbox"/> No DEA Number</p>	

Check Schedules: Sch II Sch III Sch IV Sch V

1.	Are prescription drugs to be distributed under this permit intended for export? (If yes, a permit as a freight forwarder may be required.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.	Does applicant intend to distribute prescription drug samples? (If yes, a Complimentary Drug Distributor permit is required.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	Will all required records be stored and maintained at applicant's physical address? (If no, provide the address of the establishments where all required records will be stored and maintained under question #3a.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3a.	Physical address where required records will be stored: Establishment Name:		
	Street Address:		
	City:	State:	Zip Code (+4 optional):
4.	Will the required records be computerized, automated or stored electronically?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, will you have a back-up procedure to be able to provide required records?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If electronically stored and not maintained as a scanned image, is the electronic data (used to generate reprints or the required document) maintained unchanged from the time of the actual distribution or activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Does the security system protect against tampering with computers or electronic records?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5.	Does the applicant own and sell prescription drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.	Does the applicant take physical possession of prescription drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7.	Does or will the applicant ship or otherwise physically transfer prescription drugs in or from Florida? (If no, provide name, address, and Florida permit number of the shipper/transferor).		
	Shipper's Name	Shipper's Address	Shipper's Florida Permit Number
8.	Does the applicant have credentialing policies and procedures as required by s. 499.0121(15), F.S. If yes, provide a copy of the policies and procedures. If no, provide a written explanation for the lack of a policies and procedures. Policy attached? <input type="checkbox"/> Yes <input type="checkbox"/> No Explanation attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9.	Section 499.0121(8), F.S., requires wholesale distributors to establish, maintain, and adhere to written policies and procedures, which must be followed for the receipt, security, storage, inventory, and distribution of prescription drugs. Please provide the applicant's written policies and procedures on: the receipt, security, storage, inventory, distribution/disposition of prescription drugs; distributing oldest approved stock first (FIFO); identifying, recording and reporting prescription drug losses and thefts; maintenance, retrieval and retention of required records; prescription drug recalls and withdrawals; natural		

disasters and other emergencies; and product tracing and other requirements under the federal Drug Supply Chain Security Act (DSCSA).

Label each policy and procedure specifically identifying the subject matter in the list above that is covered by the policy and procedure. For example, the policy and procedure for recalls could be labeled or identified as "Recall Policy and/or Procedure" or in another manner similar to this example.

If you are renewing your permit, you do not have to include copies of your policies and procedures.
Please check this box (N/A) and proceed to the next section.

Policy Attached?

- Receipt, security, storage, inventory, distribution/disposition of prescription drugs Yes No
- Distributing oldest approved stock first (FIFO) Yes No
- Identifying, recording and reporting prescription drug losses and thefts Yes No
- Maintenance, retrieval and retention of required records Yes No
- Prescription drug recalls and withdrawals Yes No
- Natural disasters and other emergencies Yes No
- Segregation and destruction of outdated prescription drugs Yes No
- Temperature and humidity monitoring Yes No
- Product tracing and other DSCSA requirements Yes No

Section VIII – Establishment Information

ESTABLISHMENT / FACILITY INFORMATION		
1.	<p>Is the establishment owned by the applicant? If yes, provide a current copy of the deed for the property on which the establishment is located. If the establishment is not owned by the applicant, provide a copy of the applicant's lease for the property on which the establishment is located; the original term of the lease must be at least 1 calendar year.</p> <p style="text-align: right;">Deed or lease included? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	<p>Is the applicant's establishment equipped with an alarm system to detect entry after hours and a security system protecting against theft and diversion?</p> <p>(If yes, provide a written description of the alarm and security systems, that include: the type of system and how the system is monitored)</p> <p style="text-align: right;">Description included? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>(If no, provide a written explanation of why the establishment is not equipped with an alarm or security system.)</p> <p style="text-align: right;">Explanation included? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	<p>Is there a designated quarantine area at the applicant's establishment? (If no, provide a written explanation on a separate sheet.)</p> <p style="text-align: right;">Explanation included? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	<p>Is the applicant's establishment equipped with adequate climate controls (including refrigerated and freezing storage if required for the applicant's distributed products) to ensure safe storage? (If no, provide a written explanation on a separate sheet.)</p> <p style="text-align: right;">Explanation included? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	<p>Has the establishment been inspected by the department, the U.S. Food and</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

	<p>Drug Administration or another governmental entity charged with the regulation of good manufacturing practices related to wholesale distribution of prescription drugs within the past 3 years which demonstrates substantial compliance with current good manufacturing practices applicable to wholesale distribution of prescription drugs? If yes, please provide a copy of the inspection report.</p> <p style="text-align: right;">Inspection report included? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
6.	<p>Provide the date the establishment will be ready and available for inspection. <u>This is the earliest date the applicant may be deemed complete.</u></p>	<p>___/___/20___</p>
FINANCIAL / BUSINESS INFORMATION		
7.	<p>Provide the applicant's gross annual receipts attributable to prescription drug wholesale distribution activities for the previous tax year. If this is a new applicant and there were no receipts attributable to prescription drug wholesale distribution for the previous tax year, check this box <input type="checkbox"/> and answer \$0 on the line provided.</p>	<p>\$ _____</p> <p><input type="checkbox"/> Trade Secret</p>
8.	<p>Provide the applicant's tax year (e.g. January 1, 2000 to December 31, 2000):</p> <p style="text-align: center;"> _____ to _____ <small>(Month, day) (Year) (Month, day) (Year)</small> </p>	
9.	<p>Provide evidence of a surety bond or other equivalent security, such as an irrevocable letter of credit or a deposit in a trust account or financial institution, which includes the State of Florida as a beneficiary and payable to the Professional Regulation Trust Fund. The bond or security is based on the applicant's gross receipts attributable to prescription drug wholesale distribution activities from the prior tax year. If gross receipts greater than \$10 million, the bond or security must be \$100,000. If gross receipts were \$10 million or less, the bond or security must be \$25,000.</p> <p style="text-align: center;"> <input type="checkbox"/> \$100,000 bond or security provided. <input type="checkbox"/> \$25,000 bond or security provided. </p>	<p><input type="checkbox"/> Trade Secret</p>
10.	<p>Provide a list of all wholesale distributors and manufacturers from whom the applicant purchased prescription drugs during the last tax year. The list should not include non-prescription drug vendors/sellers and must identify the seller's physical address. If the applicant is a new applicant and there were no prescription drug purchases during the last tax year, check the box indicating no purchases.</p> <p style="text-align: center;"> <input type="checkbox"/> Distributor / manufacturer list provided. <input type="checkbox"/> No purchases. </p>	<p><input type="checkbox"/> Trade Secret</p>
11.	<p>Please provide documentation (for example, sales invoices or shipping documents) that the establishment has engaged in wholesale distribution of prescription drugs throughout the year. Per s. 499.012(10)(o), F.S., there must be documentation of at least 12 wholesale distribution of prescription drugs during the previous year with at least 3 distributions within the previous 6 months. If the applicant is a new applicant and there were no wholesale distributions during the previous year, check the box indicating no wholesale distributions.</p> <p style="text-align: center;"> <input type="checkbox"/> Wholesale distribution documentation provided. <input type="checkbox"/> No wholesale distributions. </p>	<p><input type="checkbox"/> Trade Secret</p>
12.	<p>Is the applicant a member of a group purchasing organization or does the applicant intend to join a group purchasing organization within the next 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Trade Secret</p>

|

	If yes, please provide the name(s) of the group purchase organization(s):		

Section IX – Key Personnel

KEY PERSONNEL			
<p>A Personal Information Statement, containing the information required in s. 499.012(9), F.S., must be submitted for each individual named in this section. Also, for new applications, a fingerprint card and payment of \$47.00 for processing the fingerprint card is required for each individual named in this section. Fingerprints may be submitted to the Department electronically or via hard fingerprint card. Additional information on the submission of fingerprints is contained on the Personal Information Statement form.</p>			
1.	<p>Provide the name of the manager of the establishment that is applying for the permit or to renew the permit:</p>		
	<p>Manager's Name: _____</p>		
2.	<p>Provide the next four highest ranking employees responsible for prescription drug wholesale operations for the establishment:</p>		
	Employee Name:	Employee Title:	
	_____	_____	
	_____	_____	
	_____	_____	
	_____	_____	
3.	<p>Section 499.003(4), F.S., defines "affiliated party" as:</p> <ul style="list-style-type: none"> (a) A director, officer, trustee, partner, or committee member of a permittee or applicant or a subsidiary or service corporation of the permittee or applicant; (b) A person who, directly or indirectly, manages, controls, or oversees the operation of a permittee or applicant, regardless of whether such person is a partner, shareholder, manager, member, officer, director, independent contractor, or employee of the permittee or applicant; (c) A person who has filed or is required to file a personal information statement pursuant to s. 499.012(9) or is required to be identified in an application for a permit or to renew a permit pursuant to s. 499.012(8); or (d) The five largest natural shareholders that own at least 5 percent of the permittee or applicant. <p>Please provide the name of ALL affiliated parties for the establishment, indicating which category from above, that the affiliated party falls under. For example, John Doe, who is both an officer and manager of the permittee or applicant would be listed as:</p>		
		John Doe	(a), (b)
	Name	Paragraph(s)	Name
	Paragraph(s)		Paragraph(s)
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

4.	Please provide the name of all shareholders who own at least 5 percent of the corporation:			
	Shareholder Name:	Ownership %	Shareholder Name:	Ownership %
5.	Provide the name and Florida certified designated representative number (CDR #) of the applicant's certified designated representative. Per s. 499.0121(15)(d), F.S., the applicant's CDR must be physically present at the establishment during normal business hours, except for during authorized absences.			
	Name	CDR #	Name	CDR#

(This space is intentionally left blank)

Section X – Final Checklist

FINAL CHECKLIST		
1.	Appropriate Fee Included? Use the space below to calculate your fee.	
a.	Permit Fee:	\$1,600
b.	Inspection Fee (For new Florida-resident establishments):	\$150
c.	Delinquent Renewal Fee (Application postmarked less than 45 days prior to permit expiration):	\$100
	Total Fee:	_____
2.	Required Documentation/Attachments – please note, an application is incomplete if all requested documentation/attachments are not provided.	
a.	Documentation that the establishment’s fictitious name is registered with the Florida Department of State, Division of Corporations?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
b.	Documentation that the establishment’s registered agent for service of process in Florida is registered with the Florida Department of State, Division of Corporations?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
c.	Documentation of a change in ownership or control?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
d.	List of permits and/or licenses issued by any agency of the State of Florida authorizing the purchase or possession of prescription drugs at the establishment?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
e.	List of permits and/or licenses issued by other states that authorize the purchase or possession of prescription drugs at the establishment?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
f.	Copy of written policies and procedures?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
g.	Copy of executed lease or deed for property on which establishment is located?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
h.	Description of alarm system?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
i.	Description of security system?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
j.	Documentation of inspection of establishment within last 3 years?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
k.	Surety bond or other equivalent security, such as irrevocable letter of credit?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
l.	List(s) of distributors and manufacturers from whom establishment purchased prescription drugs during last tax year?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
m.	Documentation of at least 12 wholesale distributions of prescription drugs within the previous year with at least 3 distributions within the previous 6 months?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
n.	Detailed explanation and supporting documents for “yes” answers to background questions in Section V of application.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
o.	Personal Information Statements for person listed as Key Personnel?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>

Section XI – Affidavit

AFFIDAVIT

Pursuant to s. 559.79, F.S., each application for a license or renewal of a license issued by the Department of Business and Professional Regulation shall be signed under oath or affirmation by the applicant, or owner or chief executive of the applicant without the need for witnesses unless otherwise required by law.

Pursuant to s. 559.791, F.S., any license issued by the Department of Business and Professional Regulation which is issued or renewed in response to an application upon which the person signing under oath or affirmation has falsely sworn to a material statement, including, but not limited to, the names and addresses of the owners or managers of the licensee or applicant, shall be subject to denial of the application or suspension or revocation of the license, and the person falsely swearing shall be subject to any other penalties provided by law.

I UNDERSTAND THAT THE ISSUANCE OF A PERMIT BY THE DEPARTMENT ONLY AUTHORIZES THE APPLICANT TO CONDUCT REGULATED ACTIVITIES IN THE STATE OF FLORIDA UNDER THE NAME IN WHICH THE PERMIT IS ISSUED. IF THE PERMIT IS ISSUED IN THE NAME OF A DBA OR D/B/A THE APPLICANT MAY ONLY CONDUCT BUSINESS IN FLORIDA IN THE NAME OF THE DBA OR D/B/A.

I FURTHER UNDERSTAND THAT PROVIDING ADDITIONAL DBA OR D/B/A NAMES TO THE DEPARTMENT AS PART OF THE APPLICATION PROCESS IS NOT, UPON LICENSURE, AN AUTHORIZATION TO CONDUCT BUSINESS IN FLORIDA UNDER THE NAME OF THOSE ADDITIONAL DBA'S OR D/B/A'S.

I certify that I am empowered to execute this application as required by s. 559.79, F.S. I understand that my signature on this application has the same legal effect as if made under oath. To the best of my knowledge, all information contained on this application is true and correct. I understand the falsification of any information on this application may result in administrative action, including a fine, suspension, or revocation of the license.

Signature of Applicant, Owner or Chief Executive:	Date:
Print Name:	Title:

Mail completed application to:
Department of Business and Professional Regulation
Division of Drugs, Devices and Cosmetics
2601 Blair Stone Road
Tallahassee, FL 32399-1047

Personal Information Statement

CHECKLIST – IMPORTANT – Submit all items on the checklist below to ensure faster processing.

FORM	REQUIREMENTS
Personal Information Statement	<input type="checkbox"/> Make any cashier's checks, corporate checks, or money orders payable to the Florida Department of Business and Professional Regulation. <input type="checkbox"/> Sign and date the Affidavit section of the form.
	Submit the completed form with enclosures to: Department of Business and Professional Regulation 2601 Blair Stone Road Tallahassee, FL 32399-1047

GENERAL INSTRUCTIONS	
1.	TYPE OR PRINT LEGIBLY an answer to every question. Use the last page of the form to provide additional explanations to questions where the form does not have sufficient room for your response.
2.	If you previously submitted a Personal Information Statement with your company's last wholesale distributor renewal, you must complete Sections I & II, IX, X, and XI of the Personal Information Statement AND provide updates to the information requested in Sections III through VIII. If there are no updates check the box designated "no updates" in each section head.
3.	Each page of the form must be initialed and dated in the lower right corner by the person to whom this personal information statement applies.
4.	If any information provided is exempt from Florida's Public Records Law (Chapter 119, F.S.) please note this beside the response and provide the specific exemption in the statutes that is being claimed.
5.	Immediate Family Information - If a family member is deceased, provide the person's name and indicate deceased. You may then omit the rest of the information requested
6.	Fingerprints. You may submit fingerprints electronically to the Department. Information on the submission of electronic submission of fingerprinting is attached to this form. If you choose to submit your fingerprints by using a fingerprint hard card, you may obtain a card from the Division. Note: If you have undergone a criminal record check as a condition of the issuance of an initial permit or the initial renewal of a permit after January 1, 2004, then you do not need to submit a new fingerprint card or electronic fingerprints.

Personal Information Statement

If you have any questions or need assistance in completing this form, please contact the Department of Business and Professional Regulation, Division of Drugs, Devices and Cosmetics, at **850.717.1800**.

Section I.

ESTABLISHMENT INFORMATION		
Name:	Current Florida Permit No: _____	<input type="checkbox"/> N/A
Street Address:	Previous Statement Submitted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
City:	State:	Zip Code:

Section II.

PERSONAL INFORMATION			
Last/Surname:	First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		United States Citizenship? <input type="checkbox"/> Yes <input type="checkbox"/> No
Address:	City:	State:	Zip Code:

Section III.

MARITAL INFORMATION			
<input type="checkbox"/> No updates; skip to the next section.			
I am currently:			
<input type="checkbox"/> Married (includes separated)			
<input type="checkbox"/> Not married (includes single, divorced and widowed); If you are not married, leave the Spouse's information section below blank.			
SPOUSE'S INFORMATION			
Last/surname:	First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		United States Citizenship? YES <input type="checkbox"/> NO <input type="checkbox"/>
Current Address:	City:	State:	Zip Code:
Employer's Name:		Spouse's Occupation:	
Employer's Address:			
Employer's City:	Employer's State:	Employer's Telephone Number:	

Section IV

IMMEDIATE FAMILY INFORMATION				
If a family member is deceased, provide the person's name and indicate deceased. You may then omit the rest of the information requested				
CHILDREN INFORMATION				
<input type="checkbox"/> No updates; skip to the next section.				
Please provide the information requested for your adult children (age 18 or older) and their spouses, if they are married. If you have no adult children check this box <input type="checkbox"/> - N/A – and leave the section below blank.				
Child #1				
Child's Last/surname:		First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		Occupation:	
Current Address:		City:	State:	Zip Code:
Spouse's				
Last/surname:		First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		Occupation:	
Current Address (if different):		City:	State:	Zip Code:
Child #2				
Child's Last/surname:		First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		Occupation:	
Current Address:		City:	State:	Zip Code:
Spouse's				
Last/surname:		First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		Occupation:	
Current Address (if different):		City:	State:	Zip Code:
Child #3				
Child's Last/surname:		First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		Occupation:	
Current Address:		City:	State:	Zip Code:
Spouse's				
Last/surname:		First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		Occupation:	
Current Address (if different):		City:	State:	Zip Code:

Section V

PARENT INFORMATION				
<input type="checkbox"/> No updates; skip to the next section.				
Please provide the information requested for your parents and their spouses, if they are married. If your parents are deceased check this box <input type="checkbox"/> - N/A – and leave the section below blank.				
Father				
Father's Last/surname:		First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		Occupation:	
Current Address:		City:	State:	Zip Code:
Father's Spouse's Last/surname:		First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		Occupation:	
Current Address (if different):		City:	State:	Zip Code:
Mother				
Mother's Last/surname:		First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		Occupation:	
Current Address:		City:	State:	Zip Code:
Mother's Spouse's Last/surname:		First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		Occupation:	
Current Address (if different):		City:	State:	Zip Code:

Section VI

SIBLING INFORMATION				
<input type="checkbox"/> No updates; skip to the next section.				
Please provide the information requested for your adult siblings (age 18 or older) and their spouses, if they are married. If you have no adult siblings check this box <input type="checkbox"/> - N/A – and leave the section below blank.				
Sibling #1				
Sibling's Last/surname:		First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		Occupation:	
Current Address:		City:	State:	Zip Code:
Sibling's Spouse's Last/surname:		First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		Occupation:	
Current Address (if different):		City:	State:	Zip Code:
Sibling #2				
Sibling's Last/surname:		First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		Occupation:	
Current Address:		City:	State:	Zip Code:

Sibling's Spouse's Last/surname:		First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		Occupation:	
Current Address (if different):		City:	State:	Zip Code:
Sibling #3				
Sibling's Last/surname:		First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		Occupation:	
Current Address:		City:	State:	Zip Code:
Sibling's Spouse's Last/surname:		First:	Middle:	Suffix:
Date of Birth:	Place of Birth (City, County, State, Country):		Occupation:	
Current Address (if different):		City:	State:	Zip Code:

Section VII

RESIDENCES			
<input type="checkbox"/> No updates; skip to the next section.			
List all residence you have had for the last 7 years, beginning with your current residence			
Mo./Yr. – Mo./Yr. (mm/yy – mm/yy)	Street Address (including Apt. Number)	City	State

Section VIII

EMPLOYMENT HISTORY AND OFFICES HELD				
<input type="checkbox"/> No updates; skip to the next section.				
List all places of employment for the last 7 years and any office held in a business, corporation or other organization for the last 7 years, beginning with current positions.				
Mo./Yr. – Mo./Yr. (mm/yy – mm/yy)	Business Name	Position Title		Office Held
	Street Address	City	State	Telephone Number
1.	Business Name:	Position Title:		Office Held:
	Street Address:	City:	State:	Telephone Number:

--	--	--	--	--

2.	Business Name:	Position Title:		Office Held:
	Street Address:	City:	State:	Telephone Number:
3.	Business Name:	Position Title:		Office Held:
	Street Address:	City:	State:	Telephone Number:
4.	Business Name:	Position Title:		Office Held:
	Street Address:	City:	State:	Telephone Number:
5.	Business Name:	Position Title:		Office Held:
	Street Address:	City:	State:	Telephone Number:
6.	Business Name:	Position Title:		Office Held:
	Street Address:	City:	State:	Telephone Number:
7.	Business Name:	Position Title:		Office Held:
	Street Address:	City:	State:	Telephone Number:

Section IX

BACKGROUND INFORMATION	
<p>If you have previously disclosed information on your Personal Information Statement for this establishment, you may make reference to the previous submission and update as appropriate.</p>	
1.	<p>Are you or have you in the last 7 years been involved with any business, including any investments, other than the ownership of stock in a publicly traded company or mutual fund, which manufactured, administered, prescribed, distributed, or stored pharmaceutical products (prescription or over-the counter)?</p> <p>If yes, describe in detail the nature of the involvement. This should include, but not be limited to, the name and address of the business; a detailed description of what the business did; and a detailed description of your involvement, including any positions or offices held with the business, and the length of your involvement with the business.</p>
	<input type="checkbox"/> Yes <input type="checkbox"/> No

	<p>Also discuss any lawsuits in which the business was named as a party where manufacturing, administering, prescribing, distributing, or storing pharmaceutical products was at issue if you were an officer, director, owner, in management, or you were deposed or testified in any lawsuit. This should include, but not be limited to, the style (name) of the case, the jurisdiction in which the action was brought, the date the action was brought (complaint signed), a detailed summary of the allegations proven, the final judgment or order, the date in which the final judgment or order was rendered, and the current status of any disposition of the proceeding.</p>	
2.	<p>During the past 7 years, have you been the subject of any proceeding for the revocation of any license or permit in Florida or any other state?</p> <p>If yes, describe in detail the nature of the proceeding and the disposition of the proceeding. This should include, but not be limited to, the name and full address on the license or permit, the type of license or permit, the license or permit number, the agency responsible for issuing the license or permit, the style (name) of the action, the jurisdiction in which the action was brought, the date the action was brought (complaint signed), a detailed summary of the allegations proven, the final judgment or order, the date in which the final judgment or order was rendered, and the current status of any disposition of the proceeding.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	<p>During the past 7 years, have you been enjoined, either temporarily or permanently, by a court from violating any federal or state law regulating the possession, control or distribution of prescription drugs?</p> <p>If yes, describe in detail the nature of the proceeding and the disposition of the proceeding. This should include, but not be limited to, the style (name) of the case, the jurisdiction in which the action was brought, the date the action was brought (complaint signed), a detailed summary of the allegations proven, the final judgment or order, the date in which the final judgment or order was rendered, and the current status of any disposition of the proceeding.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	<p>As an adult, have you been found guilty (regardless of whether adjudication of guilt was withheld), pled guilty or pled nolo contendere of any felony under a federal, state (including Florida), or local law?</p> <p><i>(Note: a criminal offense committed in another jurisdiction that would have been or would be a felony in this state must be reported and a felony in another state that is classified as a misdemeanor in Florida may be omitted.)</i></p> <p>If yes, describe in detail the nature of the criminal proceeding and its disposition. This should include, but not be limited to, the style (name) of the case; the case number; the jurisdiction in which the action was brought; the date the action was brought (complaint signed / arraigned); a detailed summary of the charges for which you were convicted; the final judgment, order or sentence; the date in which the final judgment or order was rendered; and the current status of any disposition of the proceeding.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	<p>Have you, or a company for which you were an owner, officer, director, or</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

	<p>manager, been fined or disciplined by a regulatory agency in any state (including Florida) for any offense that would constitute a violation of Chapter 499, Florida Statutes?</p> <p>If yes, describe in detail the nature of the proceeding and the disposition of the proceeding. This should include, but not be limited to, the name and full address on the license or permit, the type of license or permit, the license or permit number, the agency responsible for issuing the license or permit, the style (name) of the action, the jurisdiction in which the action was brought, the date the action was brought (complaint signed), a detailed summary of the allegations proven, the final judgment or order, the date in which the final judgment or order was rendered, and the current status of any disposition of the proceeding.</p>	
6.	<p>Have you, or a company for which you were an owner, officer, director, or manager, had any current or previous permit or license suspended or revoked which was issued by a federal, state, or local governmental agency relating to the manufacturer or distribution of drugs or medical devices?</p> <p>If yes, describe in detail the nature of the proceeding and the disposition of the proceeding. This should include, but not be limited to, the name and full address on the license or permit, the type of license or permit, the license or permit number, the agency responsible for issuing the license or permit, the style (name) of the action, the jurisdiction in which the action was brought, the date the action was brought (complaint signed), a detailed summary of the allegations proven, the final judgment or order, the date in which the final judgment or order was rendered, and the current status of any disposition of the proceeding.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	<p>Have you, or a company for which you were an owner, officer, director, or manager, been denied a permit or license related to an activity regulated under Chapter 499, Florida Statutes in any state?</p> <p>If yes, describe in detail the nature of the proceeding and the disposition of the proceeding. This should include, but not be limited to, the name and full address on the application for the license or permit, the type of license or permit for which you were applying, the agency responsible for issuing the license or permit, the style (name) of the action, the jurisdiction in which the action was brought, the date the action was brought (complaint signed), a detailed summary of the allegations for denial, the final judgment or order, the date in which the final judgment or order was rendered, and the current status of any disposition of the proceeding.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	<p>Have you, or a company for which you were an owner, officer, director, or manager, ever held a permit issued under Chapter 499, Florida Statutes, in a different name than the company applicant's name for which you are submitting this personal information statement?</p> <p>If yes, provide the names in which each permit was issued and at what address.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	<p>Do you currently have a pending felony arrest?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

	If yes, provide details about the arrest, including but not limited to, the arrest date, the charge(s), the jurisdiction of the arrest, the case number, and next scheduled court appearance.																	
10.	<p>Do you, your spouse, or any member of your immediate family have or expect to have an ownership interest of any kind in the business for which you are submitting this personal information statement?</p> <p>If yes, provide the name of the person and the extent of the ownership interest:</p> <table border="1"> <thead> <tr> <th>Name</th> <th>%</th> <th>Name</th> <th>%</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Name	%	Name	%													<input type="checkbox"/> Yes <input type="checkbox"/> No
Name	%	Name	%															
11.	<p>Does your spouse or any member of your immediate family currently or expect to manage, control, or oversee, whether directly or indirectly, the operation of the business for which you are submitting this personal information statement?</p> <p>If yes, provide the name of the person(s):</p> <table border="1"> <thead> <tr> <th>Name</th> <th>Name</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </tbody> </table>	Name	Name							<input type="checkbox"/> Yes <input type="checkbox"/> No								
Name	Name																	
12.	<p>Please indicate how you are providing your fingerprints to the department:</p> <p><input type="checkbox"/> I am not submitting fingerprints because I previously submitted fingerprints as a condition of an initial or renewal permit after January 1, 2004.</p> <p><input type="checkbox"/> I am submitting my fingerprints electronically via an approved LiveScan Device provider.</p> <p><input type="checkbox"/> I am submitting my fingerprints via hard card obtained from the Department and submitted to FLDBPR, Florida Fingerprinting Program, Prints Inc. 119 East Park Avenue, Tallahassee, FL 32301</p>																	

Section X

CURRENT PHOTOGRAPH	
1.	Sections 499.012(9)(a)9 and 499.12(9)(d)1, F.S., require the submission of a photograph taken within 180 days of the submission of the application.
2.	The photographs must be clearly recognizable with a front, full face image.
3.	<div style="border: 1px solid black; width: 300px; height: 100px; display: inline-block;"></div> <p>Date of photograph ____/____/____.</p>

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AFFIDAVIT

Each application for a license or renewal of a license issued by the Department of Business and Professional Regulation shall be signed under oath or affirmation by the applicant. This Personal Information Statement is being submitted as part of an application for licensure or renewal of a licensed issued by the Department and must also be signed under oath or affirmation.

I have read all questions, answers and statements on the foregoing Personal Information Statement and attachments and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement voluntarily with the knowledge that false or inaccurate information, misrepresentation or the failure to reveal information requested may be deemed sufficient cause for denial, suspension, or revocation of a wholesaler permit under the Florida Drug and Cosmetic Act, Chapter 499, Florida Statutes, for the establishment identified on page 1.

Signed Under Oath this _____ Day of _____ 20____.

Signature _____

State of _____

County of _____

This personal information statement was acknowledged before me this _____ day of _____ 20____ by _____

Name of Officer & Title _____

He/she ____ is personally know to me or ____ has produced a _____

_____ as identification.

Notary public - Signature _____

Notary public - Printed Name _____

ELECTRONIC FINGERPRINTING FREQUENTLY ASKED QUESTIONS

Applicants can use any Livescan vendor that has been approved by the Florida Department of Law Enforcement (FDLE) to submit their fingerprints to the Department of Business and Professional Regulation (Department). Please ensure that the Originating Agency Identification (ORI) number is provided to the vendor when you submit your fingerprints. If you do not provide an ORI number or if you provide an incorrect ORI number to the vendor, the Department will not receive your fingerprint results. The applicant is fully responsible for selecting the vendor and ensuring submission of the prints to the department.

1. **How do I find a Livescan vendor in order to submit my fingerprints to the department?**

The Department accepts electronic fingerprinting service offered by Livescan device vendors that are approved by the Florida Department of Law Enforcement and listed at their site. You can view the vendor options and contact information at [Livescan Device Vendors List](#).

2. **What information must I provide to the Livescan vendor I choose?**

- a. You must provide accurate demographic information at the time your fingerprints are taken.
- b. You must **clearly identify the profession** for which you are seeking to be licensed or select "Temporary License for Military Spouse" and submit your fingerprints payment to the vendor. Any inaccurate information that you provide could cause a delay in processing your request.
- c. You must provide the correct ORI number.

3. **Where do I get the ORI number to submit to the vendor?**

The Division's ORI number is: **FL 924780Z**.

4. **How does the electronic fingerprinting process actually work?**

In the traditional method of fingerprinting, ink is applied to each of your fingers which are then "rolled" across a fingerprint card to obtain your prints. With electronic fingerprinting, there is no ink or card. Your fingerprints are "rolled" across a glass plate and scanned. It is faster and cleaner than the traditional method. Electronic fingerprinting reduces the likelihood of illegible fingerprints and will reduce the overall application processing time.

5. **How long will it take to have my fingerprints scanned?**

It should only take approximately 5-10 minutes.

6. **How much does electronic fingerprinting cost?**

The total fee charged by each vendor varies. Please contact the vendor to obtain this information. The fingerprint results are usually received by the department two to four days after your fingerprints are scanned.

You can view the vendor options and contact information at [Livescan Device Vendors List](#).

7. **What do I need to bring with me to the Florida electronic fingerprinting site?**

All applicants will be required to bring two (2) forms of identification to the electronic fingerprinting site on the day of scheduled fingerprinting. One of the two types of

identification **must** bear your picture and signature such as a driver's license, state identification card or passport. Applicants cannot be permitted to be fingerprinted without proper identification.

8. I submitted my fingerprint through an FDLE approved vendor, but I have now received a deficiency letter regarding my fingerprints? What should I do?

As of the date of the mailing of the deficiency letter, your electronic fingerprinting results have not been transmitted to the Department. We will not be able to process your application until we have received this information. You should contact your fingerprint vendor to determine if they have submitted the prints to the FDLE for processing.

Vendor contact information can be viewed at [Livescan Device Vendors List](#).

9. What should I do if I am notified by the Department that FDLE or the FBI determined my electronic fingerprints were illegible?

The electronic fingerprint scanning machines are equipped to determine if your fingerprints scanned successfully; however, if it is determined by the FBI that your prints were not legible, we will send you a notification letter asking you to go back to the same vendor that did your initial prints and schedule a re-roll of your prints. You will be required to bring the notification letter with you as information such as the TCN (Transaction Control Number) and TCR (Transaction Control Reference) must be identified and used at the time of the reroll.

10. How long are my fingerprints valid for?

The Department will retain results of the prints for 12 months from the date your digital fingerprints were electronically received by FDLE. FDLE only retain the prints for 6 months. If your prints have expired at the time your application is submitted to the Department, you will be required to submit new prints again. Applicants should submit their applications soon after submitting their fingerprints in order to afford themselves an opportunity to resolve any application deficiencies prior to the expiration of the criminal history results.

11. Can I use my recent prints to apply for another permit or license from the Department?

Per FBI regulation, your prints cannot be shared between divisions or with other agencies. You are required to have separate prints for each permit or license you are applying for, using the correct ORI.

12. What kind of assistance can the Department provide if I have problems with a Livescan vendor?

As an applicant, you have the choice to select a vendor approved by the FDLE. Since the Department does not approve or regulate Livescan vendors, you will be fully responsible for the fingerprint submission and for ensuring that the prints have been timely submitted to the FDLE. The Department retrieves the fingerprint results from FDLE through a secure web site. We suggest that you ask the vendor for a receipt showing payment date and other pertinent information in case you need to go back to them for assistance.

13. If I am living out of state, how do I submit my fingerprints without having to travel to Florida?

Go to the FDLE [Livescan Device Vendors list](#) and choose a Livescan vendor that is certified as "hard card scanning capable". These vendors have the ability to process fingerprints through additional methods, including the use of hard copy finger print cards.

14. What if I am living out of state and unable to secure my finger prints through a “hard card scanning” capable vendor?

If you are unable to obtain fingerprinting services through an FDLE approved “hard card scanning capable” vendor, please contact the Department by calling 850.717.1800 to request the alternative procedure for fingerprint processing and fingerprint card. Each fingerprint card has a specific ORI code identifying the profession. When requesting a card, please specify the profession for which you are seeking licensure.

Once the fingerprint card is received, you may then go to a local law enforcement office in your area to have your fingerprints rolled onto the card. Other information will be completed at the local law enforcement agency. The completed card must be mailed to the following address where they will be scanned:

**FLDBPR, Florida Fingerprinting Program
Prints Inc. 119 East Park Avenue
Tallahassee, FL 32301**

Prior to mailing your fingerprint card, you must complete the following steps <https://pearson.ibtfingerprint.com/> in order to register and make advance payment of \$51.75 plus Florida Sales Tax (do not send any money to Prints Inc).

15. What happens after I get my fingerprints done using a Livescan vendor?

The Livescan vendor will send your scanned fingerprint images to FDLE using the ORI number you provide to the vendor. The FDLE/FBI will process the fingerprints and provide the results to the Department, usually within three to five business days from the scan date. You do not have to do anything with your fingerprint results unless the department contacts you for additional information.

16. What happens if the fingerprint results indicate that I have a criminal history?

If you have a criminal history, your application will be reviewed by the department to ensure that your criminal history will not statutorily disqualify you from becoming permitted / licensed. Depending on the type of criminal offense(s) you might be required to provide additional information. You will be notified in writing of any required appearance before the board.