INDIVIDUAL HISTORY AFFIDAVIT FORM

Date Received
Office Use Only

Name: *First*	*MI*	*LAST*	**Date of Birth:**

Social Security Number:	**Telephone Number:**	**Email Address:**

Home Address: *Number and Street*	*City*	*State*	*Zip*

Company Name:	**Permit Number:**

Company Address: *Number and Street*	*City*	*State*	*Zip*

Position with Business: *(Check all that apply)*

☐ Owner ☐Partner ☐ Officer ☐ Stockholder ☐ Member ☐ Designated Representative

☐ Other: Specify_____

Provide details for any professional or vocational license held in the past five years. (Pharmacist, physician, dentist, veterinarian attorney, accountant etc.)

License Held	State Issued	License Number

1.	**Have you ever been an owner, partner, officer, or member of any business (partnerships, corporation, firm, or association) whose license was denied, revoked, suspended, surrendered or placed on probation?**	☐ Yes ☐ No
2.	**Have you ever had any professional or vocational (e.g. pharmacist, technician, pharmacy) license/registration revoked, suspended, denied, suspended, placed on probation or any other disciplinary action by any Federal or State authority?**	☐ Yes ☐ No
3.	**Have you ever been arrested and/or convicted of a felony or misdemeanor (excluding minor traffic violations that do not involve drugs or alcohol) in any state?**	☐ Yes ☐ No
4.	**Has any final judgment been entered or settlement reached resulting from a claim or action for damages caused by any error, omission or negligence in the performance of any pharmacy or pharmaceutical professional services?**	☐ Yes ☐ No

If you answered "Yes" to any of the above questions you must attach an explanation that includes the date, license type, license number, your position, state issued, and a copy of any arrest records, board orders, or court proceedings.

It is affirmed that all information provided herein is true and correct and it is recognized that providing false information may result in disciplinary action. It is understood that there must be compliance with the provisions of the Alabama Pharmacy Act, the Rules of the Board and all other applicable statutes and rules.

_____   _____
Signature   Title

_____   _____
Printed Name   Date

FORM MUST BE NOTARIZED
Subscribed and sworn to before me this _____day of _____, 20_____ A.D.

APPLICATION MUST BE NOTARIZED_____
Notary Public (seal)

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