Alabama State Board of Pharmacy
Designated Representative Change Form

Date Received
Office Use Only

Permit Details:

Name of Business:			Permit#
Business Address: *Number and Street*			
City	*State*	*Zip*	*County (If in Alabama)*

Requirements:

- **See a full list of requirements under Alabama Administrative Code 680-x-2-.23(h).**
- **This person must be a U.S. Citizen or is legally present in the United States with appropriate documentation for the Federal Government.**
- **An Individual History Affidavit Form must be completed for this person.**

680-x-2-.23 (h)(VIII)(ii) ***"If the permit holder's Designated Representative will be or is no longer employed or no longer desires to act as Designated Representative, the permit holder shall notify the board within ten (10) days of the change in Designated Representative"***

Designated Representative Details:

Name		Date of Birth	Social Security Number
Title		Email	
Phone Number		Home Address: *Number and Street*	
City	*State*	*Zip*	***Are you a U.S. Citizen?*** ☐ Yes ☐ No

Effective Date of Change: _____

Person Submitting Notice:

Name	Title
Email	Date

Mail or Email Completed Form:
Alabama Board of Pharmacy 111
Village Street
Birmingham, AL 35242
sgamble@albop.com

Application Contact Person

Date Received
Office Use Only

Applicant Business Information

Name of Business:			
Address of Business: Number and Street	*City*	*State*	*Zip Code*

Please provide the best contact details for the person to be contacted regarding any deficiencies, questions, or concerns about this application. **All correspondence regarding this application will be directed to this individual only.**

Name:	*Telephone Number:*		
Company Name:			
Business Mailing Address: Number and Street	*City*	*State*	*Zip Code*
Email Address:			

_____ _____

Signature Owner, Officer, or CEO only Title

_____ _____

Printed Name Date

We recommend adding kpickett@albop.com and sgamble@albop.com to your email contact list to help prevent missing important correspondence.

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*

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

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

☐ Other: Specify_____

1.	**Have you been arrested?**	**☐ Yes ☐ No**
2.	**Have you been convicted of a felony or misdemeanor, excluding minor traffic conviction?**	**☐ Yes ☐ No**
3.	**Have you been convicted of violating any laws regulating controlled substances or prescription legend drugs?**	**☐ Yes ☐ No**
4.	**Have you ever been issued a license to practice pharmacy or as a pharmacy technician?**	**☐ Yes ☐ No**
5.	**Has any license, permit, registration, certification or like authority issued to you or any entity you own/owned in whole or part by any board of pharmacy or any other occupational or regulatory board been sanctioned or subject to discipline in any way? If so, attach a copy of the discipline.**	**☐ Yes ☐ No**
6.	**Are you currently or have you ever been charged with a substance abuse violation or been in a substance abuse treatment program?**	**☐ Yes ☐ No**
7.	**Are there currently any pending investigations or charges regarding any license, permit or registration issued to you?**	**☐ Yes ☐ No**
8.	**Have you ever been denied, refused, or withdrawn an application for a permit or surrendered a license once issued for a pharmacy, manufacturer, wholesaler, distributor, repackager, private label distributor, 503B outsourcer and/or third-party logistics company?**	**☐ Yes ☐ No**
9.	**Have you or any entity you own/owned in whole, or part ever surrendered or failed to renew any license, permit, registrations, certification or like authority issued by any board of pharmacy or any other regulatory board? If so, list state, type of license, etc., the occupation or profession, and reason for the surrender or failure to renew.**	**☐ Yes ☐ No**
10.	**Have you or any entity you own/owned in whole or in part ever been denied any license, permit, registration, certification or like authority by any board of pharmacy or any other occupational or regulatory board? If so, list state, type of license, etc., the occupation or profession, and reason for denial.**	**☐ Yes ☐ No**
11.	**Have you been licensed, permitted, or registered in any other state(s) as a pharmacist, pharmacy technician or any other position requiring a license, permit or registration from a pharmacy board or requiring a permit involving dispensing controlled substances?**	**☐ Yes ☐ No**
12.	**Has an FDA 483 or Warning Letter ever been issued to any entity in which you have been or are currently involved/affiliated?**	**☐ Yes ☐ No**
13.	**Has any final judgement 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 by the Applicant or any Owner, Officer, Member, Director, or Partner or by you?**	**☐ 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, disciplines, 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)

8/22