



## Community Pharmacy Compounding Sterile Preparations (Class A-S) License Application (Continued)

**Type or clearly print (all blanks must be complete – if not applicable, enter N/A)**

**14 PRIMARY OWNER OR ONE OF THE MANAGING OFFICERS MUST ANSWER THE FOLLOWING QUESTIONS:**

- |   |   |   |
|---|---|---|
| <b>1.</b>   | Has the pharmacy, or the corporation, partnership, or other entity that owns the pharmacy, been the subject of <u>any</u> professional disciplinary action or are any such actions pending against this entity by a regulatory authority? (Examples: surrender, revocation, reinstatement, suspension, fine, probation, restriction). Include such information for <u>all</u> states, including Texas, and for all regulated professions. | <input type="checkbox"/> YES* <input type="checkbox"/> NO |
| *If you answered "yes" to Question #1, include the name of the Board, licensing or disciplinary authority and the date of the Order, and, if applicable, the date of the termination of the condition and/or probation. |   |   |
| <b>2.</b>   | Has the pharmacy, or the corporation, partnership, or other entity that owns the pharmacy, been subject to court ordered probation as related to any offense?   | <input type="checkbox"/> YES <input type="checkbox"/> NO  |
| <b>3.</b>   | Are the customer service areas of the Pharmacy accessible to disabled persons, as defined by federal law?   | <input type="checkbox"/> YES <input type="checkbox"/> NO  |
| <b>4.</b>   | Does the pharmacy provide translating services for customers, including translating services for a person with impairment of hearing? If yes, what type of translating services does the pharmacy provide? (check all that apply):  | <input type="checkbox"/> YES <input type="checkbox"/> NO  |
|   | <input type="checkbox"/> 1 Spanish <input type="checkbox"/> 3 Telecommunication Device for the Deaf (TDD) <input type="checkbox"/> 5 AT&T Translating Service<br><input type="checkbox"/> 2 Vietnamese <input type="checkbox"/> 4 American Sign Language <input type="checkbox"/> 6 Other _____   |   |
| <b>5.</b>   | Does this pharmacy participate in the Texas Medicaid program?   | <input type="checkbox"/> YES <input type="checkbox"/> NO  |
| <b>6.</b>   | Does this pharmacy participate in the Texas State Kids Insurance Program (SKIP)?  | <input type="checkbox"/> YES <input type="checkbox"/> NO  |

**15** ATTEST: I hereby attest that the foregoing statements, on this form or those on any attachment(s) to this form are to the best of my knowledge true and correct and that they are all given of my free will. I agree that any misstatement(s) or omission(s) as to material facts will constitute violation of and subject me to the penalties set forth in the Texas Pharmacy Act. I agree to comply with the Texas Pharmacy Act and Rules.

***THIS SIGNATURE MUST BE NOTARIZED:***

Signature of Owner / Managing Officer	Date	Subscribed and sworn to before me this _____ day of _____, 20____
Owner / Managing Officer's Name (Type or Print)		Notary Public