



**TEXAS STATE BOARD OF PHARMACY**  
**333 Guadalupe Street, Ste. 3-600 Austin, Texas 78701**  
**512-305-8021(voice) 512-305-8075 (fax) www.pharmacy.texas.gov**

Partnership or Individual Ownership Form					
Type or print clearly. Complete each and every blank. If not applicable, enter N/A					
DBA Name of Pharmacy (as listed on license application)			Name of Partnership or Individual Owner		
Pharmacy Location Address (must match pharmacy application)			Mailing Address of Partnership or Individual Owner		
Street Address		Suite/Unit #	Street Address		Suite/Unit #
City	State	Zip	City	State	Zip
Designated Person Of Contact For Pharmacy (Authorized By Owner/Officer to Discuss Application Materials with TSBP Staff)			Designated Person of Contact for Partnership or Individual Owner		
Full Name & Title:		Phone:	Full Name & Title:		Phone:
		Email:			Email:
Pharmacy Mailing Address (if different than location address)			Federal Tax Information – Federal Employer ID Number		
Street Address		Suite/Unit #			(Required see www.IRS.gov)
			Name & Address of Malpractice Insurance Carrier (Required)*		
City	State	Zip			

\*If self-insured, provide a written statement

**A. PARTNERSHIP** *(The following information must be provided for the general partner, limited partners, and the top four managing officers of the partnership.)* If any of the partners listed below is a corporation or limited liability company, form # LIC-007 (Corporation Ownership Information) must also be completed for each such entity. NOTE: The person signing the pharmacy application and ownership form must be listed below.

\* Disclosure of your social security number (or federal employer identification number, if you are a partnership) is mandatory under Tex. Fam. Code Ann. §231.302 (Vernon 1999). The SSN is provided to identify persons relative to enforcement of child support payments.

NAME OR CORPORATE NAME				STATUS	
				<input type="checkbox"/> Partner <input type="checkbox"/> Limited Partner	
HOME ADDRESS (city, state, and ZIP)					
HOME PHONE NUMBER	SOCIAL SECURITY NUMBER*	DATE OF BIRTH	TX PHARMACIST LICENSE # (if applicable)		

**Providing Address of Record Indicates You Wish the Address and Home Telephone Listed Above Maintained Confidential**

ADDRESS OF RECORD			ALTERNATE PHONE NUMBER		
CITY		STATE	ZIP		

NAME OR CORPORATE NAME			STATUS	
			<input type="checkbox"/> Partner <input type="checkbox"/> Limited Partner	
HOME ADDRESS ( <i>city, state, and ZIP</i> )				
HOME PHONE NUMBER	SOCIAL SECURITY NUMBER*	DATE OF BIRTH	TX PHARMACIST LICENSE # ( <i>if applicable</i> )	
<b>Providing Address of Record Indicates You Wish the Address and Home Telephone Listed Above Maintained Confidential</b>				
ADDRESS OF RECORD			ALTERNATE PHONE NUMBER	
CITY		STATE	ZIP	

NAME OR CORPORATE NAME			STATUS	
			<input type="checkbox"/> Partner <input type="checkbox"/> Limited Partner	
HOME ADDRESS ( <i>city, state, and ZIP</i> )				
HOME PHONE NUMBER	SOCIAL SECURITY NUMBER*	DATE OF BIRTH	TX PHARMACIST LICENSE # ( <i>if applicable</i> )	
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ADDRESS OF RECORD			ALTERNATE PHONE NUMBER	
CITY		STATE	ZIP	

NAME OR CORPORATE NAME			STATUS	
			<input type="checkbox"/> Partner <input type="checkbox"/> Limited Partner	
HOME ADDRESS ( <i>city, state, and ZIP</i> )				
HOME PHONE NUMBER	SOCIAL SECURITY NUMBER*	DATE OF BIRTH	TX PHARMACIST LICENSE # ( <i>if applicable</i> )	
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ADDRESS OF RECORD			ALTERNATE PHONE NUMBER	
CITY		STATE	ZIP	

NAME OR CORPORATE NAME			STATUS	
			<input type="checkbox"/> Partner <input type="checkbox"/> Limited Partner	
HOME ADDRESS (city, state, and ZIP)				
HOME PHONE NUMBER	SOCIAL SECURITY NUMBER*	DATE OF BIRTH	TX PHARMACIST LICENSE # (if applicable)	
<b>Providing Address of Record Indicates You Wish the Address and Home Telephone Listed Above Maintained Confidential</b>				
ADDRESS OF RECORD			ALTERNATE PHONE NUMBER	
CITY		STATE	ZIP	

**B. INDIVIDUAL OWNER** (You must provide the following information if the facility is owned by an individual, i.e., sole owner)

NAME OF INDIVIDUAL OWNER				
HOME ADDRESS (city, state, and ZIP)				
HOME PHONE NUMBER	SOCIAL SECURITY NUMBER*	DATE OF BIRTH	TX PHARMACIST LICENSE # (if applicable)	
<b>Providing Address of Record Indicates You Wish the Address and Home Telephone Listed Above Maintained Confidential</b>				
ADDRESS OF RECORD			ALTERNATE PHONE NUMBER	
CITY		STATE	ZIP	

**ATTEST:** I hereby attest that the foregoing statements 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

\_\_\_\_\_  
Owner / Managing Officer's Name (Type or Print)

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public