



Corporation/Corporate Ownership Form

Type or print clearly. Complete each and every blank. If not applicable, enter N/A

| | | | | | |
|---|--------------|---------------------|--|--------------|---------------------|
| DBA NAME OF PHARMACY <i>(as listed on license application)</i> | | | NAME OF CORPORATION <i>(owner of pharmacy)</i> | | |
| | | | | | |
| PHARMACY LOCATION ADDRESS <i>(must match pharmacy application)</i> | | | MAILING ADDRESS OF CORPORATION <i>(owner of pharmacy)</i> | | |
| STREET ADDRESS | | SUITE/UNIT # | STREET ADDRESS | | SUITE/UNIT # |
| | | | | | |
| CITY | STATE | ZIP | CITY | STATE | ZIP |
| | | | | | |
| DESIGNATED PERSON OF CONTACT FOR PHARMACY <i>(Authorized By Owner/Officer to Discuss Application Materials with TSBP Staff)</i> | | | DESIGNATED PERSON OF CONTACT FOR CORPORATION | | |
| FULL NAME & TITLE: | | Phone: _____ | FULL NAME & TITLE: | | Phone: _____ |
| | | Email: _____ | | | Email: _____ |
| PHARMACY MAILING ADDRESS <i>(if different than location address)</i> | | | FEDERAL TAX INFORMATION – FEDERAL EMPLOYER ID # | | |
| STREET ADDRESS | | SUITE/UNIT # | | | |
| | | | <i>(Required see www.IRS.gov)</i> | | |
| | | | NAME & ADDRESS OF MALPRACTICE INSURANCE CARRIER <i>(Required)*</i> | | |
| CITY | STATE | ZIP | | | |
| | | | | | |

**If self-insured, provide a written statement*

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