



Request to Change the Name or Location of Pharmacy License Instructions

Instructions:

This form should be submitted if the Pharmacy Facility is changing their Business or DBA Name or its Location. This form should also be used for an Address Correction (i.e. the addition of a suite number, but the pharmacy is NOT physically moving locations or the postal office changed the zip code, etc.). A new pharmacy license number is not required if the pharmacy facility changes its location and/or business or DBA name. However, according to the Texas Pharmacy Act, Section 291.3, a pharmacy owner must notify the Texas State Board of Pharmacy of 30 days prior to a Change of Location and within 10 days of a Change of Name.

This form is **NOT** acceptable to submit if there has been any Changes in Ownership. According to the Texas Pharmacy Act, Section 560.101, a pharmacy license is not transferable or assignable. Therefore, if a pharmacy changes ownership, the new owner will need to apply for a new license. The Change of Ownership Form is available at http://www.pharmacy.texas.gov/files_pdf/Change-Ownrshplnstr.pdf

This Change of Name or Location Request form **MUST BE**:

- Signed by the current Pharmacist-in-Charge. This signature must be notarized. Change of Pharmacist-in-Charge forms can be found at: http://www.pharmacy.texas.gov/files_pdf/Change_PIC.pdf
- Signed by the Individual Owner or by a Managing Officer of the Corporation/LLC or Partnership that owns the pharmacy. This signature must be notarized. Change of Managing Officer Forms can be found at http://www.pharmacy.texas.gov/files_pdf/LIC-021A.pdf
- Enclosed with the previously issued Pharmacy Facility License provided by the Texas State Board of Pharmacy. (Keep a copy of the application to show licensure for transition period.)
- Enclosed with a check or money order made payable to the **Texas State Board of Pharmacy** for \$100.

Additionally, **any Request to Change the Location** of a Pharmacy **MUST BE** accompanied by:

- A Copy of the Entire Lease Agreement for the property where the Pharmacy will operate. The Address listed on the Lease Agreement must match the Address listed on the form and the Tenant listed on the Lease Agreement must match the Name of the Pharmacy Owner on the form.
- If the property is being SUBLEASED, you must also submit a letter from the Landlord giving his consent to sublet the property or the Landlord must also sign the Sublease.

Alternatively, for an Address Correction, instead of a copy of the Lease Agreement, you may submit the following if it is a:

- Change to Zip Code from the Postal Service, the form must include:
 - A printout from USPS's Zip Code Look up tool: <https://tools.usps.com/go/ZipLookupAction!input.action>
- Change to Street Name due to City or 911
 - A copy of the notification received that indicates the street name is changing.
- Addition of Suite Number by Landlord
 - A copy of the entire lease agreement with the suite number listed in the address or an amendment to the lease listing the tenant's name, address, and signatures of both the landlord and the tenant.

Submit the completed notarized application form and all supporting documents to Texas State Board of Pharmacy by postal mail. Due to the notarized signatures, we do not accept copies or faxes. Failure to enclose all documents together will result in a delay in approval. The amended license will be mailed once all requirements are met. Allow 10 business days from the approval date for the amended license to be received via US Postal Service.

Verify current records at: http://www.pharmacy.texas.gov/dbsearch/phy_search.asp. The website is updated every Monday thru Friday at noon.

Request to Change the Name or Location of a Pharmacy Facility License

Read the previous instructions before filling out the form. Failure to enclose supporting documents will result in a delay of approval.
Fill out form completely. Do not leave any box blank. If not applicable, put N/A.

Fee:	\$100.00	Anticipated Move or Effective Date:	
Pharmacy License Number:		Request to Change the:	<input type="checkbox"/> Name <input type="checkbox"/> Location <input type="checkbox"/> Both
Name of the Direct Pharmacy Owner (Corporation, LLC, Partnership, or Individual Owner – if a Sole Proprietorship):			
Requested New Pharmacy Business or DBA Name:		Current Pharmacy Business or DBA Name:	
Requested New Pharmacy Location Address:		Current Pharmacy Location Address:	
Street Address	Suite/Unit #	Street Address	Suite/Unit #
City	State	Zip Code	City
			State
			Zip Code
Pharmacy Contact Information			
Phone Number	()	Email Address	
Fax Number	()	Web Address	
Type of Pharmacy <i>(Must indicate one)</i>	Description of Services – Check all that apply <i>(Must indicate at least one)</i>		
<input type="checkbox"/> Community Independent <input type="checkbox"/> Community Multi <input type="checkbox"/> Hospital Independent <input type="checkbox"/> Hospital Multi <input type="checkbox"/> Public Health <input type="checkbox"/> Other: _____	<input type="checkbox"/> 24 Hour Service <input type="checkbox"/> Alternate Visitation Schedule <input type="checkbox"/> Closed Door <input type="checkbox"/> Compounding Sterile, LOW Risk <input type="checkbox"/> Compounding Sterile, MED Risk <input type="checkbox"/> Compounding Sterile, HIGH Risk	<input type="checkbox"/> Compounding, Non-Sterile <input type="checkbox"/> Compounding, Office Use <input type="checkbox"/> Home Delivery <input type="checkbox"/> Infusion <input type="checkbox"/> Inpatient Prescriptions <input type="checkbox"/> Nuclear	<input type="checkbox"/> Outpatient Prescriptions <input type="checkbox"/> Outpatient Surgery <input type="checkbox"/> Pharmacist Admin. Immunizations <input type="checkbox"/> Shipping Prescriptions Out-of-State <input type="checkbox"/> Veterinary Prescriptions <input type="checkbox"/> Other: _____
Staff Pharmacists and Technicians		List of Managing Officers	
Name (attach list if needed)	License/Registration No.	List the Top 4 Managing Officers. If any changes, see previous instructions about submitting a Change of Managing Officer Form.	
		1	
		2	
		3	
		4	

By my signature, I acknowledge that I am in the Pharmacist-in-Charge of this Pharmacy and attest that I have read and understand the laws and rules relating to this class of pharmacy. THIS SIGNATURE MUST BE NOTARIZED.			
		Subscribed and sworn to before me this	
Print or Type Name of Pharmacist in Charge	TX License No		
		_____ Day Of _____	, 20 _____
Signature of Pharmacist in Charge	Date	Notary Public	

ALL APPLICANTS MUST ANSWER THE FOLLOWING QUESTIONS:

1	Has the pharmacy, the pharmacy's owner or partner (if the pharmacy is owned by a corporation or partnership) been the subject of any professional disciplinary action or are any such actions pending against you by a regulatory authority? (Examples: denial, surrender, revocation, reinstatement, suspension, fine, reprimand, probation, restriction). Include such information for all states, including Texas, and for all regulated professions. *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. Response must include the name of the person who was the subject of the disciplinary actions.	<input type="checkbox"/> Yes* <input type="checkbox"/> No
2	For any criminal offense, including those pending appeal, has the pharmacy, the pharmacy's owner or any officer or partner (if the pharmacy is owned by a corporation or partnership), within the last 36 months:	
	A. Been Arrested?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
	B. Been charged with a crime but not arrested?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
	C. Pled nolo contendere?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
	D. Pled Guilty?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
	E. Received deferred adjudication for a misdemeanor?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
	F. Received deferred adjudication for a felony?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
	G. Been convicted of a misdemeanor?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
	H. Been convicted of a felony?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
	*In answering questions #2A-H, include all offenses even those for which you subject to deferred adjudication. (Examples: assault, theft, theft by check, driving while license suspended, possession of controlled substances, public intoxication, DWI, driving under the influence of drugs.) Response must include the name of the person who was subject of the disciplinary action.	
3	Has the pharmacy, the pharmacy's owner or any officer or partner (if the pharmacy is owned by a corporation or partnership) been subject to court ordered probation or confinement as related to any offense, within the last 36 months?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
4	Has the pharmacy, the pharmacy's owner or any officer or partner (if the pharmacy is owned by a corporation or partnership) served time in prison for any offense within the last 36 months?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
5	Has the pharmacy, the pharmacy's owner or any officer or partner (if the pharmacy is owned by a corporation or partnership) been convicted of a drug or alcohol related offense, or been subject to a deferred adjudication for this offense, within the last 36 months? (Examples: possession of a controlled substances, public intoxication, DWI, driving under the influence of drugs)	<input type="checkbox"/> Yes* <input type="checkbox"/> No
6	Is the pharmacy's owner or partner (if the pharmacy is owned by a corporation or partnership) a registered sex offender or has the owner or partner ever been required to register as a sex offender in Texas or any other state?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
	*If you answered "yes" to Questions #3-6, include the name and location of the court, the offense charged, a brief explanation of the offense, the date of action, and if applicable, the date that probation or confinement ended. Response must include the name of the person who was the subject of the disciplinary action.	
7	Are the customer service areas of the pharmacy accessible to disable persons, as defined by federal law?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
8	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"/> Spanish	<input type="checkbox"/> American Sign Language
	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> AT&T Translating Service
	<input type="checkbox"/> Telecommunication Device for the Deaf (TDD)	<input type="checkbox"/> Other: _____
9	Does this Pharmacy participate in the Texas Medicaid Program?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
10	Does this Pharmacy participate in the Texas State Kids Insurance Program (SKIP/CHIP)?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
	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 before me this _____ Day Of _____, 20____
_____ Owner/Managing Officer's Name (Type or Print)	_____ Notary Public	