



**Alabama State Board of Pharmacy  
Designated Representative Change/Update Form**

Date Received
Office Use Only

**Permit Details:**

Name of Business:			Permit#
Business Address: <i>Number and Street</i>			
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: <i>Number and Street</i>	
City	State	Zip	<b>Are you a U.S. Citizen?</b> <input type="checkbox"/> Yes <input type="checkbox"/> 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**



# INDIVIDUAL HISTORY AFFIDAVIT FORM

Date Received
Office Use Only

<b>Name:</b> First MI LAST			<b>Date of Birth:</b>
<b>Social Security Number:</b>	<b>Telephone Number:</b>	<b>Email Address:</b>	
<b>Home Address:</b> 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 and/or convicted of a felony or misdemeanor, excluding minor traffic convictions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever had any action against your personal professional or vocational license (Pharmacist, Physician, Dentist, etc) that resulted in any disciplinary action such as suspension, probation, or revocation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you ever owned or now own in whole or part any pharmacy, manufacturer, wholesaler, distributor, repackager, private label distributor, 503B Outsourcer, and/or third-party logistics company?  If so, has any license or permit issued to any described entity been surrendered or subject to discipline in connection with the activities of any such entity or charged and/or convicted of any felony or misdemeanor excluding minor traffic violations?	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Have you ever been denied or refused an application for a permit for a pharmacy, manufacturer, wholesaler, distributor, repackager, private label distributor, 503B Outsourcer and/or third-party logistics company?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Have you ever withdrawn an application for a permit or surrendered license once issued to any pharmacy, manufacturer, wholesaler, distributor, repackager, private label distributor, 503B Outsourcer, and/or third-party logistics company?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Have you ever owned in whole or in part or now own any entity that has been denied, refused or withdrawn an application for a permit or license of a pharmacy, manufacturer, wholesale distributor, repackager, private label distributor, 503B Outsourcer and/or third-party logistics company?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have you ever been issued a license to practice pharmacy or as a pharmacy technician?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Has an FDA 483 or Warning Letter ever been issued to any entity in which you have been or are currently involved/affiliated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	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 you or any entity that you have been an Owner, Officer, Member, Director, or Partner thereof?	<input type="checkbox"/> Yes <input type="checkbox"/> 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, 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)