GUAM BOARD OF EXAMINERS FOR PHARMACY

Department of Public Health & Social Services
Tel: (671) 735-7405~12
194 Hernan Cortez Ave., Terlaje Bldg. Ste 213A Hagatna, GU, 96910

www.dphss.guam.gov

FOR OFFICIAL USE ONLY:
□ Fees
□ Inspection
□ Approved
□ License # (upon approval) _________

APPLICATION FOR PHARMACY/FACILITY

____ New ____Renewal

APPLICANTS PLEASE NOTE: EVERY PERMIT UNDER THIS AUTHORITY SHALL BE DEEMED TO BE PERSONAL AND MAY NOT IN ANY CIRCUMSTANCES BE TRANSFERRED TO ANY OTHER PERSON. A SEPARATE APPLICATION MUST BE FILED FOR EACH PERMIT. THERE MUST BE A PERMIT FOR EACH SEPARATE BUSINESS LOCATION.

1. FULL NAME OF APPLICANT

____
(Last) (First) (Middle)

DOING BUSINESS AS (**Business, Trade or Fictitious Name**)

____
(Completed Name of Business)

TYPE OF LICENSE (**Check one only**)

/ / Wholesaler/distributor / / Retail Pharmacy / / Manufacturer

/ / Virtual Wholesaler / / Telepharmacy / / Virtual Manufacturer

/ / Non-resident Pharmacy / / Nuclear Pharmacy / / Hospital / Institutional Pharmacy

/ / Non-sterile Compounding / / Sterile Compounding / / Third-party logistics (3PL)

2. BUSINESS MAILING ADDRESS

____
(P.O. Box or Street #)

BUSINESS LOCATION (**Block, Lot No., Municipality**)

____
(Physical Location)

Telephone #: ______________________

Email address: ______________________

Fax #: ______________________

Guam Business License #: ______________________

3. TYPE OF FIRM (**Check and Complete one**)

_____a. CORPORATION

1. Is Business a Foreign (other than Guam) Corporation? ___Yes ___No
2. Is it registered under the law of Guam? ___Yes ___No
3. Name of Agent: ______________________
4. Title of Agent: ______________________
5. Local Address of Agent: ______________________
   (Agent is authorized to accept services of process in legal proceeding against the Corporation)

_____b. PARTNERSHIP (**List name and address of each partner**)

1. ______________________________ ______________________
(Last) (First) (Middle) (Address)

2. ______________________________ ______________________
(Last) (First) (Middle) (Address)

3. ______________________________ ______________________
(Last) (First) (Middle) (Address)

_____c. SOLE PROPRIETORSHIP

_____d. OTHER: Specify: ____

4. TYPE OF PHARMACEUTICAL/SERVICE

a. Prescription only:
   1. Non-Controlled ___
   2. Controlled ___
   3. Both ___

b. Over-the-counter (OTC) Only: ___

c. Prescription and OTC ___

d. Cognitive pharmacy services ___

5. GOVERNMENT OF GUAM APPLICABLE LICENSE/PERMIT (PLEASE ATTACH)

a. Government of Guam Controlled Substance Registration Number ______________________

b. DEA Registration Number ____

c. NPI Number ____

6. BUSINESS INTENTION:

____ distribute, mail prescription drugs into Guam

____ distribute, mail prescription drugs to Guam prescribers only

____ pharmacy practice with direct dispensing of medications

____ pharmacy practice without direct dispensing of medications

7. IF APPLICABLE:

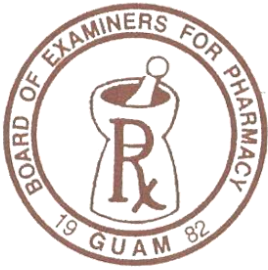
a. Name of Manager ____
b. Name of Pharmacist-in-Charge (if a pharmacy) ______________________ Guam License # __________
c. Out-of-state Applicants:
   Home State: ______________________________ Home State License # __________

I certify that I have personally read and will abide by the Laws, Rules and Regulations governing the Practice of Pharmacy on Guam. I understand that I am required to report any changes in the information contained in this application to the Board.

I hereby swear or declare under penalty of perjury that the information provided in this application is true and correct. I understand that failure to provide complete and truthful information may constitute grounds for denial, revocation, or other disciplinary sanctions against the pharmacy license.

______________________________________ ______________________

Signature of Applicant, Title of Capacity ***Date***



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RECORD OF PAYMENT

IDENTIFICATION

Name ____
(Last) (First) (Middle)

Mailing Address ____
(Street or P.O. Box #) (City) (State) (Zip Code)

Signature ______________________ Date ______________________

VERIFICATION OF LICENSURE: *Please print the complete name used on original license and your Social Security number.*

Name______________________ SS# ______________________

FEE: Fee paid is **NON-REFUNDABLE.** Make all checks or money orders payable to **TREASURER OF GUAM.**

Please check your request(s):

1.	( )	Pharmacist's Licensure Application fee (charged once)	$100.00
2.	( )	Pharmacist's License Renewal fee	$60.00
3.	( )	Temporary License fee	$10.00
4.	( )	Pharmacy Permit fee	$50.00
5.	( )	Pharmacy Permit Renewal fee	$30.00
6.	( )	Pharmacy Intern Application fee	$40.00
7.	( )	Pharmacy Intern Renewal fee	$40.00
8.	( )	Pharmacy Technician License fee	$50.00
9.	( )	Pharmacy Technician License Renewal fee	$30.00
10.	( )	Penalty for late renewal of Pharmacy Intern	$40.00
11.	( )	Miscellaneous permit fee (Wholesalers, Drug Outlets, etc.)	$50.00
12.	( )	Miscellaneous Permit Renewal	$30.00
13.	( )	Penalty for late renewal of Pharmacist's license	$40.00
14.	( )	Penalty for late renewal of Pharmacy license	$40.00
15.	( )	Photocopying of rules and regulations (per set)	$10.00
16.	( )	Photocopying of Public Law (Pharmacy Portion) (per set)	$5.00
17.	( )	Photocopying of other records (first 5 copies)	$3.00
18.	( )	Photocopying (each additional sheet)	$0.50

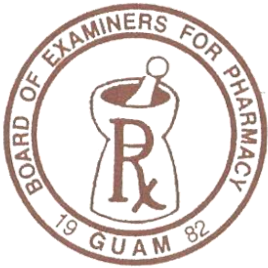
Present this form with payment to cashier at Treasurer's office, then return the processed form to GBEP Office.

Off-island applicants, return this form with payment to GBEP at the above address.

OFFICE USE ONLY: *Payment* *( ) Check* *( ) Money Order* *( ) Cash* *( ) Credit Card*

Receipt #: ______________________ *Date Paid:* ____________ *Staff Initials:* ________

Account #:DPH 324156346



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GBEP-7 [R 12/2017]