



Idaho State Board of Pharmacy

1199 W Shoreline Lane Ste 303 Boise, Idaho 83702-9103 <http://bop.idaho.gov>
P.O. Box 83720 Boise, Idaho 83720-0067 208.334.2356 208.334.3536 fax

Required Documents Designated Representative Personal Information Statement

Minimum Requirements of a Designated Representative – Review Idaho Code 54-1753(4)(b) & IDAPA 807.03, to ensure minimum requirements are met to be a Designated Representative for an Idaho licensed wholesale facility.

1. Complete application form – answer all questions and complete all fields, if a question/field does not apply enter 'N/A' for not applicable.
2. Question 2a & Business Interest (pg.4) and the identification of lawsuits against the business;
 - Only answer yes and provide information regarding those lawsuits against the business that also involved your participation in the same lawsuit as a named party or (regardless of whether or not you were a named party) as a witness at trial or as a witness in a deposition.
 - Provide the name of the case, the court and jurisdiction in which the case was filed, and the nature of your involvement in that case, such as named party, trial witness and/or deposition witness.
3. Application fee; see application form
4. Previous Residential Address; indicate your residences for the past seven (7) years. Make copies of the form as necessary.
5. Employment History; form must be completed as the Board does not accept or interpret resumes. Complete the Designated Representative Employment Form for each of your occupations, positions of employment and office held during the past seven (7) years. Make copies of the form as necessary. Designated Representative - Past 7-year employment history, begin with current employment and explain any employment lapses.
6. Photo of the Designated Representative: must be taken within the previous year; passport photos are preferred.
7. Completed fingerprints; Fingerprints can be taken at most local law enforcement or other agency authorized to obtain fingerprints. Note some agencies will charge a nominal fee for fingerprinting.
8. Completed Non-Criminal Justice Applicant Privacy Statement; submit copy
9. Copy of government issued photo identification (i.e. Driver's License or Passport)



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Designated Representative Personal Information Statement Background Check Fee \$32.00

Wholesale Facility Name: _____ License #: _____

Designated Representative Name: _____

DOB: _____ SSN#: _____

Home Address: _____

City: _____ State: _____ Zip: _____ + _____

Work Email: _____

Work Ph#: _____ Work Fax #: _____

1. Do you complete regular training programs related to the federal and state laws concerning wholesale distribution of prescription drugs? No Yes

Have you at any time: (If yes to any of the following submit all related documentation)

1. Have you, during the last 7 years, been enjoined, either temporarily or permanently, by a court of competent jurisdiction from violating any federal or state law regulating the possession, control or distribution of prescription drugs or criminal violations? No Yes
2. Have you, in the last 7 years, been involved in any business, including any investments, other than ownership of stock in a publicly traded company or mutual fund, which manufactured, administered, prescribed, distributed or stored pharmaceutical products? No Yes, must complete Business Interest Form
 - a. If yes, were there any lawsuits in which such business was named as a party and in which you were also a named party in the same lawsuit or, regardless of whether or not you were a named party, in which you testified as a witness at trial or in a deposition? No Yes
3. Have you, as an adult, been found guilty of any felony criminal offense, regardless of whether adjudication of guilt was withheld or whether you pled guilty or nolo contendere? No Yes
 - a. Is any felony conviction presently under appeal? No Yes, attach a copy of the notice of appeal of the felony conviction. You must within fifteen (15) days after the disposition of the appeal, submit to the Board of Pharmacy a copy of the final written order of disposition of your appeal.
4. Have you been, in the last 7 years, the subject of any proceeding for the revocation of any license or any criminal proceeding? No Yes, attach a statement setting forth the details of each event.



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Previous Residential Address:

Begin Date: _____ **End Date:** _____

Home Address: _____

City: _____ State: _____ Zip: _____ + _____

Begin Date: _____ **End Date:** _____

Home Address: _____

City: _____ State: _____ Zip: _____ + _____

Begin Date: _____ **End Date:** _____

Home Address: _____

City: _____ State: _____ Zip: _____ + _____

Begin Date: _____ **End Date:** _____

Home Address: _____

City: _____ State: _____ Zip: _____ + _____

Begin Date: _____ **End Date:** _____

Home Address: _____

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Business Interest:

Current: Business Interest:

Company: _____

City: _____ State: _____ Zip: _____ + _____

Phone: _____

Description of Involvement: _____

Previous: Begin Date: _____ End Date: _____

Company: _____

City: _____ State: _____ Zip: _____ + _____

Phone: _____

Description of Involvement: _____

Previous: Begin Date: _____ End Date: _____

Company: _____

City: _____ State: _____ Zip: _____ + _____

Phone: _____

Description of Involvement: _____

Previous: Begin Date: _____ End Date: _____

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City: _____ State: _____ Zip: _____ + _____

Phone: _____

Description of Involvement: _____



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Employment History:

Current: Begin Date: _____ **End Date:** _____

Company: _____

City: _____ State: _____ Zip: _____ + _____

Position/Title: _____

Is your position in a capacity related to the dispensing and distribution of, and recordkeeping relating to prescription drugs? No Yes, Years: _____ Months: _____

Previous: Begin Date: _____ **End Date:** _____

Company: _____

City: _____ State: _____ Zip: _____ + _____

Position/Title: _____

Was your position in a capacity related to the dispensing and distribution of, and recordkeeping relating to prescription drugs? No Yes, Years: _____ Months: _____

Previous: Begin Date: _____ **End Date:** _____

Company: _____

City: _____ State: _____ Zip: _____ + _____

Position/Title: _____

Was your position in a capacity related to the dispensing and distribution of, and recordkeeping relating to prescription drugs? No Yes, Years: _____ Months: _____

Previous: Begin Date: _____ **End Date:** _____

Company: _____

City: _____ State: _____ Zip: _____ + _____

Position/Title: _____

Was your position in a capacity related to the dispensing and distribution of, and recordkeeping relating to prescription drugs? No Yes, Years: _____ Months: _____



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Attach passport
photo here

Oath

I, _____, the undersigned, am the Designated Representative of _____ and swear this oath or make this affirmation or declaration on my own behalf, and do hereby swear or affirm that the information contained in this Personal Information Statement is true and correct (there are _____ pages included in this application).

Signature of Designated Representative

Date

State of _____)

County of _____)

I, _____, a notary public, do hereby certify that on this _____ day of _____, 200_, personally appeared before me (name) _____, who, being by me first duly placed under oath, swore or affirmed that (he/she) is the Designated Representative of (company) _____, that he/she signed the foregoing Designated Representative Personal Information Sheet and that the information contained in said application is true and correct.

Notary Public

SEAL

My commission expires on _____, 20__.