



Idaho State Board of Pharmacy

3380 Americana Terrace #320
208/334-2356

PO Box 83720

Boise ID 83720-0067
208/334-3536 Fax

Instructions – Designated Representative

The following documents must be submitted with the Designated Representative Personal Information Statement:

- Question 2a and the identification of lawsuits against the business; you need 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.
- Employment Form: Was your position in a capacity related to the dispensing and distribution of, and recordkeeping relating to prescription drugs? ***If yes, list the total number of years and months in which you were employed in such capacity.*** (Board Rule 324.01.b requires a minimum 3 years experience in this area.)
- Photo of the Designated Representative taken within the previous year; passport photos are acceptable. ***No scanned photos will be accepted.***
- Finger Print card containing legible fingerprints of each of the digits on each of the Designated Representative's hands and properly completed by a law enforcement agency or approved vendor; submitted in sealed envelope. Prints will be submitted to Idaho State Police for FBI background check.

Fingerprint cards must be submitted as per the protocols attached to the print cards. Print cards that are not properly sealed will be shredded.

In order to be processed the Designated Representative forms must be complete. If a question does not apply to applicant use N/A.



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Designated Representative Personal Information Statement

~ Type or print clearly ~

Name: _____

Previous name(s) or AKA: _____

Date of Birth: _____ SSN#: _____

Place of Birth: _____

Current Residence Address: _____

City: _____ St: _____ Zip: _____

Email _____ Work Phone _____ Work Fax _____

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, *attach a statement setting forth the details of each event.*

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, *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, *attach a statement setting forth the name of the case, the court and jurisdiction in which the case was filed, and the nature of your involvement in the case.*

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, *attach a statement describing each felony conviction, the date of conviction, and the jurisdiction in which the conviction occurred*
 - 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.*
5. Have you met the training requirements set forth in IDAPA 27.01.01.325.02 Yes No
- ⇒ **02. Continuing Training for Designated Representative.** A licensed wholesale distributor's designated representative must receive and complete: (4-2-08)
- ⇒ **b.** *If no formal continuing education is specified by the Idaho Board of Pharmacy, training programs that address applicable federal and state laws regarding wholesale distribution of prescription drugs and are provided by qualified in-house specialists, outside counsel, or consulting specialists with capabilities to help ensure compliance. (4-2-08)*
6. Complete the Residential Address form indicating your residences for the past seven (7) years. Make copies of the form as necessary.
7. 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.



Residential Address past 7 years

~Type or print clearly~

Current Residential Address

Address

City, St, Zip

Begin: End:

previous Residential Address

Address

City, St, Zip

Begin: End:

previous Residential Address

Address

City, St, Zip

Begin: End:

previous Residential Address

Address

City, St, Zip

Begin: End:

previous Residential Address

Address

City, St, Zip

Begin: End:

Designated Representative – Business Interest Form

~ Type or print clearly ~

<i>Business Interest – Begin:</i>		<i>end:</i>
Company		
Address		
City, St, Zip		
Phone		
Description of involvement:		
<i>Business Interest – Begin:</i>		<i>end:</i>
Company		
Address		
City, St, Zip		
Phone		
Description of involvement:		
<i>Business Interest – Begin:</i>		<i>end:</i>
Company		
Address		
City, St, Zip		
Phone		
Description of involvement:		

Designated Representative - Employment Form

~ Type or print clearly ~

Past 7-year employment history, begin with current employment and explain any employment lapses

<i>Current Employment – Start date:</i>		<i>End Date:</i>	
Company			
Address			
City, St, Zip Phone			
Position or Title:			
Was/is your position in a capacity related to the dispensing and distribution of, and recordkeeping relating to prescription drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes, _____years _____months			
<i>previous Employment – Start date:</i>		<i>End Date:</i>	
Company			
Address			
City, St, Zip Phone			
Position or Title:			
Was/is your position in a capacity related to the dispensing and distribution of, and recordkeeping relating to prescription drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes, _____years _____months			
<i>previous Employment – Start date:</i>		<i>End Date:</i>	
Company			
Address			
City, St, Zip Phone			
Position or Title:			
Was/is your position in a capacity related to the dispensing and distribution of, and recordkeeping relating to prescription drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes, _____years _____months			

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.

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

S E A L

My commission expires on _____, 20____.