



Virgin Islands Board of Pharmacy Managing Officer Form

Submit a separate form for EACH Managing Officer for the new pharmacy license.

This form must be filled out completely and accurately.

Failure to fill out the form completely will result in delay of licensure.

If not applicable put N/A

The ORIGINAL supplemental form and all required attachments shall be mailed to:

Virgin Islands Department of Health, Office of Professional Licensure, P.O. Box 222995, Christiansted, VI 00822

Each officer must provide a home (main address which will be considered the confidential address of record AND an alternate address which may be provided to the public. You may enter the same address in both address types.

Each individual owner, managing officer, or partner must attach a copy of their current Driver's License or state-issued identification card.

This application should be submitted with a NEW Pharmacy Application or Change in Ownership Pharmacy Application **ONLY**. To Add/Remove Managing Officers on an Existing Pharmacy, submit the **Change of Managing Officer Form**

Pharmacy Information

Pharmacy Name

Physical Address

Street Address

City

State

Zip Code

Managing Officer Information

Full Legal Name of Individual

Title of Officer

VI Pharmacist License #

Date of Birth (mm/dd/yy)

Physical Address

Street Address

City

State

Zip Code

Mailing Address

Street Address

City

State

Zip Code

Home Phone Number

Cell Phone Number

Email Address

Public Address (Alternate Address to be Provided to the Public) - REQUIRED

Street Address

City

State

Zip Code

If the individual holds any other professional and/or regulatory licenses, provide the following information below
(Examples: Pharmacist in another state, Physician, Registered Nurse, etc)

License Type	License #	State	Expiration Date

EACH OF THE FOLLOWING QUESTIONS MUST BE ANSWERED BY THE OFFICER BEING ADDED: *(circle appropriate answer)*

1. Have you been the subject of ANY professional disciplinary action or are such actions pending against you by a regulatory authority? (e.g., denial, surrender, revocation, reinstatement, suspension, fine, reprimand, probation, restriction). Include such information for ALL states and territories and for ALL regulated professions.
- Yes* No

*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.

2. For any criminal offense, including those pending appeal, have you ever:

a. Been Arrested?	Yes*	No
b. Been Charged with a crime but not arrested?	Yes*	No
c. Pled nolo contendere?	Yes*	No
d. Pled Guilty?	Yes*	No
e. Received deferred adjudication for a misdemeanor?	Yes*	No
f. Received deferred adjudication for a felony?	Yes*	No
g. Been convicted of a misdemeanor?	Yes*	No
h. Been convicted of a felony?	Yes*	No

*If you answered "yes" to questions #2 A-H, include all offenses even those for which you are subject to deferred adjudication. (e.g., assault, theft, theft by check, driving while license suspended, possession of controlled substances, public intoxication, DWI, driving under the influence of drugs.)

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|--|------|----|
| 3. Have you been subject to a court ordered probation or confinement as related to any offense? | Yes | No |
| 4. Are you a registered sex offender or have you ever been required to register as a sex offender in any state or territory? | Yes | No |
| 5. Have you ever been licensed, certified, or registered with another state or territory Board of Pharmacy as a pharmacist, pharmacist intern, or pharmacy technician? | Yes* | No |

* If you answered "yes" to question #5, indicate the type of license, certification, or registration that you received, the dates of registration and the registration number.

Attest: I hereby attest that by submitting this form, I request to be listed as an Owner/Managing Officer of the above mentioned pharmacy license, and the foregoing statements on this form and those on the attachment(s) to this form are to the best of my knowledge true and correct and that they are 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 Virgin Islands Pharmacy Practice Act and Rules. I agree to comply with the Virgin Islands Pharmacy Act and Rules.

Signature of Owner/Managing Officer

Date

THIS SIGNATURE MUST BE NOTARIZED.

Statement of Notary Public

Subscribed and sworn before me this _____ day of _____, 20 _____

Seal Here

Notary Public _____

My commission expires: _____