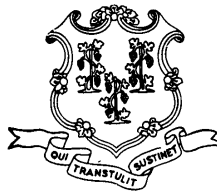


**STATE OF CONNECTICUT**  
**DEPARTMENT OF CONSUMER PROTECTION**  
**DRUG CONTROL DIVISION**  
**COMMISSION OF PHARMACY**  
 Email: [dcp.pharmacylicense@ct.gov](mailto:dcp.pharmacylicense@ct.gov)  
 Website: [www.ct.gov/dcp](http://www.ct.gov/dcp)



For Official Use Only
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## APPLICATION FOR A CHANGE OF PHARMACY MANAGER FOR AN OUT- OF- STATE PHARMACY

<b>INSTRUCTIONS:</b>			
1. All spaces on this form must be completed.			
2. This application must be accompanied by a check or money order in the amount of <b>\$90.00</b> made payable to "Treasurer, State of Connecticut." Application fees are non-refundable.			
3. If applicable, complete all the appropriate change forms as needed based on the changes to your business.			
4. Mail this completed application and fee to: Department of Consumer Protection, License Services Division, 450 Columbus Blvd, Ste. 801, Harford, CT 06103			

Pharmacy Information			
Pharmacy Name			CT Pharmacy License #
Address	City	State	Zip Code
Telephone Number	Email Address to be used for all correspondence		

Outgoing Pharmacy Manager Information		
Outgoing Pharmacy Manager Name	Pharmacy Manager License #	End Date

New Pharmacy Manager Information		
New Pharmacy Manager Name	Pharmacy Manager License #	Start Date

Email Address to be used for all correspondence	
1. Has the new Pharmacy Manager ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please attach a statement including the date(s) of the conviction(s), the court(s) where the case(s) were decided and a description of the circumstances involved.	
2. Has any Federal or State registration held by the applicant been surrendered, revoked, suspended, limited or denied or is any such action pending? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, attach a statement including the date(s) of the conviction(s), the courts(s) where the case(s) were decided and a description of the circumstances involved.	

Certification	
By signing this form, I certify that the information contained in this application is the truth to the best of my knowledge and have attached all of the documents required that are applicable to this registration.	
Printed Name of New Pharmacy Manager	
Signature of New Pharmacy Manager	Date