



OKLAHOMA STATE BOARD OF PHARMACY

4545 Lincoln Blvd, Ste 112, Oklahoma City, OK 73105-3488

Phone: (405) 521-3815 / Fax: (405) 521-3758

www.pharmacy.ok.gov / e-mail: pharmacy@pharmacy.ok.gov

FORM A. INDIVIDUAL OR PARTNERSHIP OWNERSHIP INFORMATION

The following MUST be submitted with this document and your application for pharmacy license:

1. If Limited Partnership –
CERTIFICATE OF LIMITED PARTNERSHIP
2. If Limited Liability Partnership –
STATEMENT OF QUALIFICATION

NOTE: A copy of the written Partnership Agreement must be made available to the Board if the Board so requests.

A. PLEASE TYPE OR PRINT CLEARLY (ALL Sections must be completed. If not applicable, enter N/A.)

NAME OF PHARMACY	
ADDRESS OF PHARMACY (include city, state and ZIP)	
NAME OF PARTNERSHIP OWNER OF PHARMACY (if applicable)	
ADDRESS OF PARTNERSHIP (if applicable)	
FEDERAL EMPLOYER ID NUMBER OF OWNER	PHONE NUMBER

B. INDIVIDUAL OWNER. You must provide the following information if the pharmacy has a sole owner, i.e. owned by an individual.

NAME	
ADDRESS (include city, state and ZIP)	PHONE NUMBER
OK BOARD OF PHARMACY LICENSE # (if applicable)	

C. PARTNERSHIP (You must provide the following information for each general & limited partner of the partnership listed in Section A above.) If any of the partners listed below is a partnership or corporation, a separate business entity form (e.g. Form A, B1, B2 or C) must also be completed for each partner. Total ownership percentages must equal 100%. If additional space is needed, please attach a separate sheet.

PARTNER NAME 1	STATUS
	___ PARTNER ___ LIMITED PARTNER ___ %OWNERSHIP
ADDRESS OF RECORD (include city, state and ZIP)	PHONE NUMBER
OK BOARD OF PHARMACY LICENSE # (if applicable)	

FORM A. INDIVIDUAL OR PARTNERSHIP OWNERSHIP INFORMATION - continued

PARTNER NAME 2	STATUS
	___ PARTNER ___ LIMITED PARTNER ___ %OWNERSHIP
ADDRESS OF RECORD (include city, state and ZIP)	PHONE NUMBER
OK BOARD OF PHARMACY LICENSE # (if applicable)	

PARTNER NAME 3	STATUS
	___ PARTNER ___ LIMITED PARTNER ___ %OWNERSHIP
ADDRESS OF RECORD (include city, state and ZIP)	PHONE NUMBER
OK BOARD OF PHARMACY LICENSE # (if applicable)	

PARTNER NAME 4	STATUS
	___ PARTNER ___ LIMITED PARTNER ___ %OWNERSHIP
ADDRESS OF RECORD (include city, state and ZIP)	PHONE NUMBER
OK BOARD OF PHARMACY LICENSE # (if applicable)	

ATTEST: I hereby attest that the foregoing statements or those on any attachment(s) to this form are to the best of my knowledge true and correct and that they are all 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 Oklahoma Pharmacy Act. I agree to comply with the Oklahoma Pharmacy Act and Rules.

THIS SIGNATURE MUST BE NOTARIZED:

Signature of Owner / Managing Officer

Date

Print Name & Title of Owner / Managing Officer

Subscribed and sworn to before me this _____ day of _____, 20 ____ .

Notary Public