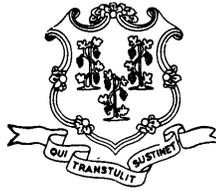


**STATE OF CONNECTICUT**  
**DEPARTMENT OF CONSUMER PROTECTION**  
**DRUG CONTROL DIVISION**  
**COMMISSION OF PHARMACY**  
 Email: [dcp.pharmacylicense@ct.gov](mailto:dcp.pharmacylicense@ct.gov)  
 Website: [www.ct.gov/dcp](http://www.ct.gov/dcp)



For Official Use Only

## APPLICATION FOR A CHANGE OF AN IN-STATE PHARMACY MANAGER

**INSTRUCTIONS:**

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 **\$90.00** made payable to "Treasurer, State of Connecticut." Application fees are non-refundable,
3. The new pharmacy manager must have already gone before the Commission of Pharmacy as a first time manager. If the new pharmacy manager has not gone before the Commission of Pharmacy as first time manager, this completed application and all required attachments must be submitted no later than fifteen (15) days prior to the next regularly scheduled Commission of Pharmacy meeting. Only complete applications will be added to the agenda. To confirm the date and time of the next available Commission of Pharmacy meeting, please email [dcp.pharmacycommission@ct.gov](mailto:dcp.pharmacycommission@ct.gov).
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 #	
Street Address	City	State	Zip Code
Telephone Number	Email Address to be used for all correspondence		

**Outgoing Pharmacy Manager**

Outgoing Pharmacy Manager Name	CT Pharmacist License #	End Date
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**New Pharmacy Manager**

New Pharmacy Manager Name	CT Pharmacist License #	Start Date
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Email Address to be used for all correspondence

1. Has the new Pharmacy Manager ever been convicted of a felony?  Yes  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?  Yes  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 license.

Printed Name of New Pharmacy Manager	
Signature of New Pharmacy Manager	Date