MINNESOTA
BOARD OF PHARMACY

Facility Manager or Designated Representative Affidavit Change Form

This form is to be completed by the primary designated representative when the representative at the facility is changing. This designated representative serves as a manager and is responsible for ensuring the facility follows all state statutes and rules applicable to the operations. This form is not intended for pharmacy applicants, please submit the applicable Pharmacist-in-Charge form.

Instructions: Complete each section, if a section does not apply, put N/A in the space available. If the space available is insufficient, use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s), each statement is subject to verification. All applicants are advised that this personal history record is an official document and misrepresentation or failure to reveal information requested may be deemed to be enough cause for the refusal or revocation of a license for the facility named in this application.

Complete the information below for the Facility

(name and address of business for which designated representative is requested)

Legal Name of Licensee	Address	City	State	Zip

Email	Minnesota License #	e-Profile #	Phone

New Applicant Information

Facility Manager or Designated Representative responsible for operations and compliance of applicant facility

Full Legal Name	Title	Academic Credentials	Date of Birth	Email

Mailing Address	City	State	Zip	Last 4 Digits of Social Security #

Old Applicant Information

Full Legal Name	Title	Academic Credentials	Date of Birth	Email

Mailing Address	City	State	Zip	Last 4 Digits of Social Security #

The Facility Manager or Designated Representative for the Applicant Facility must personally complete and attest to the following points of fact regarding this facility's operations.

Read each statement carefully, following the instructions below

- If the statement is true, review and attest to each statement below by marking YES.
- If the statement is not true, mark NO **and** provide a detailed explanation on a separate document referencing the statement.

I certify the following:

○ Yes	○ No	I am the Facility Manager or Designated Representative for the Applicant Facility.
○ Yes	○ No	I have never been convicted of, or plead guilty to any felony violation.
○ Yes	○ No	I have no convictions under federal, state, or local law relating to distribution of prescription drugs or controlled substances.
○ Yes	○ No	The Applicant Facility has adequate storage conditions to allow for the safe receipt, storage, handling, and transfer of drugs.
○ Yes	○ No	The Applicant Facility has sufficient policies and procedures in place for the inspection of all incoming and outgoing drug shipments.
○ Yes	○ No	There is a functioning security system that includes an after-hours central alarm or comparable entry detection capability.
○ Yes	○ No	There are security policies and procedures that include provisions for restricted access to the premises, comprehensive employee applicant screening, and safeguards against all forms of employee theft.
○ Yes	○ No	The Applicant Facility maintains records of the handling of drugs, which shall be kept for a minimum of two years and be made available to the board upon request.
○ Yes	○ No	I will ensure that all personnel have sufficient education, training, and experience, in any combination, so that they may perform assigned duties in a manner that maintains the quality, safety, and security of drugs.

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Read each statement carefully, following the instructions below.

- If the statement is true, review and attest to each statement below by marking YES.
- If the statement is not true, mark NO and provide a detailed explanation on a separate document referencing the statement.

I certify the following:

○ Yes	○ No	I will ensure that all employees of the Applicant Facility will be evaluated and supervised sufficiently to protect and maintain the quality, safety, and security of drugs.
○ Yes	○ No	I will develop and, as necessary, update written policies and procedures that ensure reasonable preparation for, protection against, and handling of any facility security or operation problems, including, but not limited to, those caused by natural disaster or government emergency, inventory inaccuracies or drug shipping and receiving, outdated drug, appropriate handling of returned goods, and drug recalls.
○ Yes	○ No	I am regularly on-site and actively involved in and aware of the Applicant Facility's actual daily operations.
○ Yes	○ No	I am physically present at the Applicant Facility during normal business hours except when absence is authorized, including but not limited to sick leave and vacation leave.
○ Yes	○ No	I serve as the Facility Manager or Designated Representative for more than one Applicant Facility or licensee.
○ Yes	○ No	I will operate in compliance with all state and federal laws and regulations applicable to Applicant Facility.

Acknowledgment

I, the undersigned, do hereby certify that all the information contained in form and the accompanying application and documents is true and correct and that the Applicant Facility will be operated in compliance with all applicable laws and regulations.

FURTHER AFFIANT SAYETH NOT.

_____ _____ _____
Facility Manager or Designated Representative Signature | Print Name | Date

Notary Acknowledgment

State of _____. I certify the following person personally appeared before me on this day, acknowledging that he or she signed the foregoing document _____.
Name of Facility Manager/Designated Representative

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

_____
Notary Signature

_____
Print Name of Notary

_____
Date Notary Commission Expires

(Seal)

Minnesota Board of Pharmacy
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