State of Florida
Department of Business and Professional Regulation
Drugs, Devices, and Cosmetics Program

Application for Certified Designated Representative
Form No.: DBPR-DDC-226

APPLICATION CHECKLIST – IMPORTANT – Submit all items on the checklist below with your application to ensure faster processing.

APPLICATION	APPLICATION REQUIREMENTS
Application for Certified Designated Representative	☐ Enclose the fee of $150.00. ☐ Make cashier's check or money order payable to the Florida Department of Business and Professional Regulation. ☐ Submit Personal Information Statement, fingerprint card, and $47.00 fingerprint processing fee. ☐ Sign and date the Affidavit section of the application.
	Submit the completed application with enclosures to: Department of Business and Professional Regulation 1940 North Monroe Street Tallahassee, FL 32399

General Information	
1.	Examination. To become certified an applicant must receive a passing score of at least 75 percent on the Certified Designated Representative examination. The examination is very rigorous and tests the candidate's knowledge of state and federal laws and rules governing the distribution of prescription drugs. An applicant must pass the examination within 6 months of being notified that (s)he is eligible or the application will be denied.
2.	Experience. An applicant for examination as a Certified Designated Representative must demonstrate that the applicant has at least 2 years of verifiable full-time: a. Work experience in a pharmacy licensed in this state or another state, where the applicant's responsibilities included, but were not limited to, recordkeeping for prescription drugs; b. Managerial experience with an establishment licensed and authorized in this state or in another state to wholesale distribute prescription drugs; OR c. Managerial experience with the United States Armed Forces, where the applicant's responsibilities included, but were not limited to, recordkeeping, warehousing, distributing, or other logistics services pertaining to prescription drugs.
3.	Please see sections 499.012(9) and (16), Florida Statutes and Rule 61N-1.015(9), Florida Administrative Code, for more information regarding the Certified Designated Representative licensing requirements.

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If you have any questions or need assistance in completing this application, please contact the Department of Business and Professional Regulation, Drugs, Devices and Cosmetics Program, at **850.717.1800.** ***For additional information see the Instructions at the beginning of this application.***

Section I- Application Type

CHECK ONE OF THE APPLICATION TYPES
☐ New Application [3314/1010]

Section II – Applicant Information

APPLICANT INFORMATION		
Applicant's Name (Last, First, Middle, Former)		
Social Security Number:	Date of Birth:	
APPLICANT'S RESIDENCE ADDRESS		
Street Address		
City:	State:	Zip Code (+4 optional):
Residence Telephone Number	Work Telephone Number	Fax Number
Email Address:		
APPLICANT'S MAILING ADDRESS (only if different from residence address)		
Street Address or PO Box:		
	State:	Zip Code (+4 optional):
E-Mail Address:	Fax Number:	
EMPLOYMENT INFORMATION		
Establishment Name (If applicable):		
Establishment Address:		
City	State	Zip Code (+4 optional)
List Establishment Florida Permit Number (If applicable)		

Section III – Work Experience

WORK EXPERIENCE			
WORK EXPERIENCE – (TO BE COMPLETED FOR INITIAL CERTIFICATION AS DESIGNATED REPRESENTATIVE) List all qualifying experience earned in and out of state. The applicant must have 2 years of verifiable full-time: • Work experience in a pharmacy licensed in this state or another state, where the person's responsibilities included, but were not limited to, recordkeeping for prescription drugs; • Managerial experience with an FDA-registered drug establishment that is licensed in Florida or in another state and authorized to distribute prescription drugs; or • Managerial experience with the U.S. Armed forces where the person's responsibilities include recordkeeping, warehousing, distributing, or other logistics services pertaining to prescription drugs.			
Name of Employer:		Dates of Employment: From: ___________ To: ____________ Total Years/Months of qualifying experience: ____________________	
Street Address:		Phone No.:	
City:		State:	Zip Code (+4 optional)
Type of Employer:			
☐	Florida permitted pharmacy (resident or nonresident)	Permit No.:	
☐	Pharmacy Licensed in the State of: _______________	Permit No.:	
☐	Florida permitted prescription drug wholesale distributor (resident or out-of-state)	Permit No.:	
☐	Prescription drug wholesale distributor permitted in the State of: _________________	Permit No.:	
☐	Florida permitted prescription drug manufacturer (resident or nonresident)	Permit No.:	
☐	Prescription drug manufacturer licensed/permitted in the State of: ________________ and authorized to wholesale distribute prescription drugs.	Permit No.:	
☐	Florida permitted prescription drug repackager.	Permit No.:	
☐	Prescription drug repackager licensed/permitted in the State of: ____________ and authorized to wholesale distribute prescription drugs.	Permit No.:	
☐	U.S. Military	Branch:	
Provide name, title, and work telephone number of person having direct knowledge of your experience. Name: Title: Work Telephone Number:			
Describe your duties that would qualify as work experience as outlined above.			

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Street Address:	Phone No.:	
City:	State:	Zip Code (+4 optional)

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Section IV– Affidavit

AFFIDAVIT	
Each application for a license or renewal of a license issued by the Department of Business and Professional Regulation shall be signed under oath or affirmation by the applicant without the need for witnesses unless otherwise required by law. I certify that I am empowered to execute this application as required by Section 559.79, Florida Statutes. I understand that my signature on this application has the same legal effect as if made under oath. To the best of my knowledge, all information contained on this application is true and correct. I understand the falsification of any information on this application may result in administrative action, including a fine, suspension, or revocation of the license.	
Signature of Applicant	Date:
Print Name:	Title:

Mail completed application to:

Department of Business and Professional Regulation
1940 North Monroe Street
Tallahassee, FL 32399