APPLICATION FOR REGISTRATION
COMMUNITY HEALTH CLINIC

(Expires March 31 Annually)

APPLICATION REQUIREMENTS:

$140.00 application or owner/location change fee - All fees are non-refundable.

If you answer "YES" to any disciplinary action questions, including pending disciplinary actions, all notices, citations, etc. and fully executed Board orders must be provided along with a detailed explanation.

Legible 8.5" x 11" floor plan, which identifies the location of drug storage, sinks, refrigerators, windows and doors. Windows and doors must be marked as secured or unsecured.

***Priority processing will be given to complete applications.** All applications submitted to the Board that are not complete and processed within 6 months will be expired. Once expired, applicants who wish to continue with the application process must reapply by submitting a new application, along with all documentation, and all fees.

Mail completed application and all required documentation to:	**Questions? Contact us:**
Oregon Board of Pharmacy 800 NE Oregon Street, Suite 150 Portland OR 97232	Telephone: (971) 673-0001 www.oregon.gov/pharmacy pharmacy.licensing@bop.oregon.gov

Please read the following instructions for applicants for registration as a Community Health Clinic (CHC).

This application is for a facility that utilizes a Registered Nurse to dispense medications to a client for the purpose of birth control, caries prevention, the treatment of amenorrhea, the treatment of a communicable disease, hormone deficiencies, urinary tract infections or sexually transmitted diseases by a practitioner who has been given dispensing privileges by their licensing Board, or a Registered Nurse who is an employee of a clinic or local public health authority (LPHA), and is recognized by the Oregon Public Health Division for the purposes of providing public health services.

1. Oregon Administrative Rule Chapter 855, Division 043 (OAR 855-043-0700 through 0750) contains additional information and requirements regarding the CHC registration.

2. The Board will issue a registration once all required documentation and fee(s) have been submitted and the application is approved. A Registered Nurse may not dispense drug products in this location until a registration is issued.

3. ***NEW OR RELOCATED FACILITIES must submit a legible 8.5" x 11" floor plan***, drawn to scale (can be hand drawn). Floor plans must identify the location of drug storage, sinks, refrigerators, windows and doors. Additionally, **you must note** whether windows/doors are secured or unsecured.

4. Each company or location address, even if under common ownership, must submit a separate application for registration.

5. You must pay a registration fee for each application for **a New Registration, an Ownership Change or a Location Change**. The Board can only accept payment by check or money order. **All fees are non-refundable.**

   Examples of a required ownership change application include but are not limited to: corporate restructure; LLC to a Corporation, Corporation to LLC; acquisition of assets; or additions or deletions of an owner. An ownership change requires submission of a copy of the sales agreement or other documentation that verifies proof of new ownership.

   If you are completing these forms to report a **Name Change** only, you do not pay a fee.

6. Per OAR 855-043-0715, the registered CHC must maintain written policies and procedures for drug management, including security, acquisition, storage, dispensing and drug delivery, disposal and record keeping. Below is general information on what the policies should include.

A. Drug Security
- Who has access?
- How are the drugs secured?
- Controlled Substances?

B. Drug Acquisition
- Where do you purchase drugs from?
- Who verifies that the wholesaler, manufacturer or pharmacy is registered with the Oregon Board of Pharmacy?

C. Drug Storage
- Where are drugs stored?
- How is proper drug storage maintained?

D. Drug Dispensing, including preparation, labeling and delivery
- Describe prescription filling, labeling and dispensing processes.
- Detail all items included on prescription label.
- Who performs the drug utilization review and final verification of all drugs dispensed?

E. Drug Disposal
- Who is responsible to quarantine and dispose of outdated, adulterated, or otherwise unwanted drugs?
- Which staff is permitted to perform these duties?
- How are drug recalls handled?

F. Personnel
- Staff Training
  - Initial and ongoing
- Accountability/Responsibility
  - Describe each personnel's responsibilities
- Drug Access

G. Record Keeping/Documentation
- Where and how are all related records to the above P&Ps stored?

H. Other

7. Oregon law **requires** each facility to conduct an annual self-inspection by completing a self-inspection report by ***July 1st*** annually.

   The self-inspection report form is available on the Board's website. This form needs to be completed and available for inspection by the Board at all times. The purpose of the self-inspection is to ensure the CHC is in compliance with state and federal laws and rules governing the drug outlet.

8. **Oregon Revised Statues and Administrative Rules** are accessible on our website at: https://www.oregon.gov/pharmacy/Pages/Laws-Rules.aspx.

Please be aware that your application will be scheduled for review once all required paperwork and fee(s) are received. Your registration is to be in your possession ***PRIOR*** to dispensing drug products.

Community Health Clinic registrations expire March 31 annually and fees are not prorated. Renewal notices will be mailed out mid-January.

APPLICATION FOR REGISTRATION

FOR BOARD USE ONLY	[0312] $ 140.00 [0326] $ 25.00
RECEIPT #	
CHECK #	
ENTERED BY	
PERSON ID #	
APPLICANT ID #	

COMMUNITY HEALTH CLINIC
(Expires March 31 Annually)
Oregon Board of Pharmacy
800 NE Oregon Street, Suite 150
Portland OR 97232
pharmacy.licensing@bop.oregon.gov

Please check all that apply:

☐ **Community Health Clinic Registration** **Fee:$ 140.00**

☐ **Laws & Rules per set, please indicate quantity_____** **Fee: $ 25.00**

TOTAL ENCLOSED:_____

ALL FEES ARE NON-REFUNDABLE

Type of Application – Check all that apply:

☐ **New Facility Application - Start / Effective Date:** _____

☐ **Change of Ownership or** ☐ **Location Change – Effective Date of Change:** _____

A change of ownership or location **requires** the submission of a new application and registration fee **within 15 days**.

Registration Number: _____

☐ **Legal documentation of the change in ownership or control, for example, a stock purchase agreement and/or and executed contract for sale, etc.**

☐ **Registration Reinstatement (Registration has been lapsed for a period of one year or more)**

Registration Number: _____

☐ **Name Change Only (No fee required)**

Registration Number: _____

Please PRINT or TYPE

WARNING: ORS 689.405(1) The furnishing of false information is grounds to deny registration.

Trade or Business Name (DBA): _____

Full Legal / Owner Name: _____

Federal Tax ID # or Owner SSN: _____

Physical Location Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ FAX #: _____

Registration & Renewal Mailing Address: _____

City, State, Zip: _____

Licensing Contact Person: _____ Title: _____ Contact Phone: _____

Licensing Contact Person E-mail Address: _____

Facility Website: _____

Hours / Days Establishment is open: _____AM to _____PM _____Through_____

Facility Contact Person: _____Title:_____Contact Phone:_____

Facility Contact Person Email Address_____

Please answer all of the following:

1. Has disciplinary action been taken, or is any such action currently pending or proposed against any of the persons or establishments listed on this application, by any State or Federal Authority in connection with a violation of any federal or state drug law or regulation? If "yes", attach a detailed explanation of the incident and describe any penalty incurred. You must provide a copy of all documents pertaining to discipline. This includes Notice of Disciplinary Actions, Board Orders and other related documents.	☐Yes ☐ No
2. Before purchasing a drug from any distributor, do you verify that the vendor is legally authorized to sell the drug?	☐Yes ☐No
3. Are all registered nurses that will dispense drugs registered / licensed appropriately with their healthcare board?	☐Yes ☐No
4. Is this facility a small business? A small business is defined as a corporation, partnership, sole proprietorship or legal entity, which is independently owned and operated from all other businesses and which has 50 or fewer employees?	☐Yes ☐No

List registered nurse(s) names and license numbers below:

Name:	License Number:

The undersigned hereby certifies that all the information contained in this application for registration is complete, true and correct and that all the provisions of the law relative to the conduct of business operating there under will faithfully be observed. I also understand that under ORS 689.405(1) the furnishing of any false information is grounds for denial of registration.

Print Name of Dispensing Practitioner	Signature of Dispensing Practitioner	Date

Ownership Information

Type of Ownership:

☐ Publicly Held Corporation ☐ Corporation ☐ Limited Liability Company ☐ Sole Proprietorship

☐ Partnership – Including Limited Liability Partnership and Limited Partnership ☐ Charitable Organization

☐ Government / Educational Institution

Owner Name _____

Parent Company Name (If owned by another entity) _____

Complete the information below for all owners. You must include at a Registered Agent and at least one of the following: CEO, President, Owner, or Members of LLC. If a corporation, include the names of the corporate officers and the names of the stockholders who own the five largest interests.

1. Name and Title _____

Title _____

SSN/Federal Tax ID _____

Address _____

City, State, Zip _____

Phone Number _____

Email Address _____

2. Name _____

Title _____

SSN/Federal Tax ID _____

Address _____

City, State, Zip _____

Phone Number _____

Email Address _____

3. Name _____

Title _____

SSN/Federal Tax ID _____

Address _____

City, State, Zip _____

Phone Number _____

Email Address _____

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Facility Attestation Form

Part 1 – Responsible Party Information - To be completed by an authorized individual of the applicant. This must be an individual who may legally sign on behalf of the business and is responsible for compliance with Oregon Laws and Rules.

First Name:_____ Last Name:_____

Title:_____

Contact email:_____

Facility Name:_____

Facility Address:_____

Facility City, State, Zip:_____

Part 2 – Attestation - To be completed by the responsible party listed above (person who may legally sign for the business). *Must be manually signed in ink.*

Per Oregon Revised Statue 689.405(1) The furnishing of false information is grounds to deny registration.

I swear or affirm that all information, statements, answers, and representations made in this application and the documents attached are true and correct, that the individuals at this facility are familiar with the laws and rules of the Oregon Board of Pharmacy as well as applicable federal laws, and that the business will be operated in compliance with all applicable laws and regulations.

Signature:_____ Date:_____

Printed Name:_____

FINAL CHECKLIST:	
1.	Appropriate Fee Included?
☐ $140.00 application or owner/location change fee **Total Fee Enclosed:**_____	
2.	Required Documentation* – an application is incomplete if all requested documentation is not provided. *Priority processing will be given to complete applications. All applications submitted to the Board that are not complete and processed within 6 months will be expired. Once expired, applicants who wish to continue with the application process must reapply by submitting a new application, along with all documentation, and all fees.
B.	☐ If you answer "YES" to any disciplinary questions, disciplinary actions, pending disciplinary actions and fully executed Board orders must be provided along with a detailed explanation**.**
C.	☐ Legible 8.5"x11" Floor Plan of facility, drawn to scale (can be hand drawn). Floor plans must identify the location of drug storage, sinks, refrigerators, windows and doors. You must note whether windows/doors are secured or unsecured.
D.	☐ Completed Facility Attestation Form
E.	☐ All signatures

The undersigned hereby states that all the information contained in this application for registration is complete, true and correct, that they have read and are familiar with the applicable laws and rules of the Oregon Board of Pharmacy, and that such provisions of the law will be faithfully observed.

_____	_____	_____
Signature	Title (Owner, Partner, Etc.)	Date

ALL RETURNED PAYMENTS WILL BE ASSESSED A $35.00 RETURNED PAYMENT FEE PURSUANT TO ORS 30.701(5)