

2011 MANUFACTURER ANNUAL RENEWAL– Supplemental Information Form

Oregon Board of Pharmacy
800 NE Oregon Street, Suite 150
Portland OR 97232



Please PRINT or TYPE **WARNING:** ORS 475.135(1) (e) and ORS 689.- 405(1) The furnishing of false information is grounds to deny registration.

Business Name _____

License Number _____ Federal Tax ID # _____

Location Address _____

City, State, Zip _____

Phone Number _____ FAX # _____

Is the address listed above the primary mailing address for license and renewals? [] Yes [] No

If No, please complete the mailing information below:

Mailing Address _____

City, State, Zip _____

Contact Person _____ Title _____ Contact Phone _____

Email Address: _____

You MUST provide at least one of the following FDA registration numbers:

(a) New Drug Application number (NDA) _____

(b) Abbreviated New Drug Application number (ANDA) _____

(c) Labeler Code number (LC) or National Drug Code Number (NDC) _____

(d) FDA Central File Number (CFN) _____

(e) FDA Establishment Identifier number (FEI) _____

Please answer all of the following:

1. [] Yes [] No Has disciplinary action ever been taken, or is any such action currently pending against any of the persons 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.

2. [] Yes [] No Before distributing a drug or prescription device, do you verify that the recipient is legally authorized to receive the drug or prescription device?

3. [] Yes [] No Do you physically manufacture product(s) at the location listed above? If "yes", list the product(s) that you manufacture.

Product(s) Manufactured or Repackaged: _____

If "no", identify below who manufactures your product(s) under contract. If there is insufficient space on this form, you may attach additional sheets.

If Applicable Contract Manufacturer(s): (Name(s) & Address(es)) _____

Note: All drug outlets, including contract manufacturers, must register with the Oregon Board of Pharmacy. If there is insufficient space on this form, you may attach additional sheets.

4. [] Yes [] No Do you own the drugs and/or devices you manufacture? If "no", please list the owner(s) and explain your relationship i.e. contract manufacturer.

If Applicable Please list Owner, NDA or ANDA holder(s) and your relationship: _____

5. [] Yes [] No Do you possess any drugs or prescription devices at this location?

6. [] Yes [] No Does your name appear on the label of the product(s) that are being manufactured?

If no, please explain: _____

7. [] Yes [] No Do you physically distribute any drugs or prescription devices that you do not manufacture or repackage?

Products: _____

* If "yes", you need to apply for a **Wholesaler Registration** in addition to this registration.

8. Please list the primary distributors you use to ship into Oregon. This includes your exclusive distributors, third-party logistics providers and wholesalers.

Distributors' name(s) and address(es): _____

_____ If there is insufficient space on this form, you may attach additional sheets.

Ownership Information

Owner Name _____

Parent Company Name (If owned by another entity) _____

Complete this section for all corporate officers or members.

1. 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 _____

2. Name _____

Title _____

SSN/Federal Tax ID _____

Address _____

City, State, Zip _____

Phone Number _____

Email Address _____

4. Name _____

Title _____

SSN/Federal Tax ID _____

Address _____

City, State, Zip _____

Phone Number _____

Email Address _____

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

Print or Type Name of Applicant

Signature of Applicant or Authorized Individual

Date