

2011 WHOLESALER II 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: _____

Please check all that apply to this location.

- [] Prescription Medical Device Distributor [] Non-Prescription Medical Device Distributor [] State or Local Government Agency [] Distributor of Drugs Exclusively for Veterinary Use [] Board Approved Non-Profit Entity [] OTC Distributor

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 in 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 purchasing a drug or prescription device from any vendor, do you verify that the vendor is legally authorized to sell the drug or prescription device?
3. [] Yes [] No Before distributing a drug or prescription device, do you verify that the recipients are legally authorized to receive the drug or prescription device?
4. [] Yes [] No Do you possess any drugs or prescription devices at this location?
5. [] Yes [] No Do you manufacture any of the drugs or prescription devices you distribute?

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All Wholesalers must complete a **Self-Inspection Report** by September 1 annually. This report form is available on our website and must be retained at the facility and be made available to the Board upon request. Do not send this report to the Board unless it is specifically requested.

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 _____

Facility Contact Representative

Name/Title _____

Address _____

City, State, Zip _____

Phone Number _____

Fax _____

Email Address _____

Normal Business _____

Hours of Facility: _____

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