

2009 WHOLESALER 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 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 from any vendor, do you verify that the vendor is legally authorized to sell the drug?

3. [] Yes [] No Before distributing a drug, do you verify that the recipients are legally authorized to receive the drug?

4. [] Yes [] No Is the facility **VAWD Accredited** through the **NABP**? If **YES**, submit a copy of your accreditation certificate to renew your license. If you have submitted an application to **NABP** mark pending below and indicate the date it was submitted.
[] Pending _____ Date: _____

5. [] Yes [] No If **NO**, have you been inspected within the last three years by a state whose inspection report has been approved by the Oregon Board of Pharmacy? Approved states are listed on our website. (Out-of-state companies only). Submit a copy of your \$100,000 Surety Bond, as well as a copy of the inspection report to renew your license.

6. [] Yes [] No Do you possess any drugs at this location?

7. [] Yes [] No Do you take title to any of the drugs you distribute?

If you answered "no" to both questions 6 and 7, you may need to register as a Drug Distribution Agent under OAR 855-062-0003 instead of as a Wholesaler. Application may be found at www.pharmacy.state.or.us.

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.

Designated Representative of Facility

Designated Representative requirements are in Oregon Administrative Rule 855-065-0009. Note: You must notify the Board in writing of a change in Designated Representative within 15 days of the change by re-submitting this form.

Designated Representative Information:
Name _____
Address _____
City, State, Zip _____
Phone Number _____
Fax _____
Email Address _____
Normal Business Hours of Facility _____

Please answer all of the following:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you the Designated Representative of more than one wholesale distributor? If "yes", attach a sheet with an explanation and details.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you actively involved in and aware of the daily operations of the wholesale distributor? If "no", attach a sheet with an explanation and details.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you physically present at the wholesale distributor during normal business hours? If "no", attach a sheet with an explanation and details.

Publicly Held Corporation Yes No

If No, Owner Name _____

Parent Company Name (If owned by another entity) _____

Ownership Information

Complete this form for all owners. If publicly held corporation, list CEO or President and Registered Agent. This page may be duplicated as needed.

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 Designated Representative signing this document acknowledges reading and understanding the responsibilities of a Designated Representative in Oregon Administrative Rule 855-065-0009. Further, 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