

APPLICATION FOR REGISTRATION

HOSPITAL DRUG ROOM

(Expires March 31 Annually)

OREGON BOARD OF PHARMACY
800 NE OREGON STREET, SUITE 150
PORTLAND, OR 97232
TELEPHONE (971) 673-0001
www.pharmacy.state.or.us



FOR BOARD USE ONLY [0309] 75.00

RECEIPT # _____

CHECK # _____

ENTERED BY _____

HOSPITAL DRUG ROOM

FEE: \$75.00

ALL FEES ARE NON REFUNDABLE

- [] New Outlet Start Date _____
- [] Owner Change Date Effective _____ Former license number _____
- [] Location Change Date Effective _____ Former license number _____

A change of ownership or location **requires** the submission of a new application and registration fee within 15 days. Please check the appropriate box regarding application status: [] Name change only – (no fee required)

Please PRINT or TYPE

WARNING: ORS 475.135 (e) The furnishing of false information is grounds to deny registration.

Pharmacy Name _____

Location Address _____

Phone Number () - FAX # () -

City, State, Zip _____

License & Renewal Mailing Address _____

City, State, Zip _____

Contact Person _____ Title _____ Contact Phone _____

Federal Tax ID # _____ Does this Hospital belong to a chain? [] Yes [] No

Hospital Ownership: *If owned by a corporation, please complete line 4 below:

- [] Corporation (Name and address of corporation officers and registered agent.) [] Individual Owner, Trustee or Receiver. (Enter name, title & address below.) [] Partnership (List below names and addresses of the 4 largest share holders.)

NAME	TITLE	MAILING ADDRESS & PHONE
1.		
2.		
3.		
4. *Corporation Name	*Date Organized (if new)	*State in which incorporated

PLEASE CHECK ONE:

- [] I wish to have my registration application processed on the date you receive my COMPLETE APPLICATION and PAYMENT in your office. Because the Oregon Board of Pharmacy does not prorate fees, **I realize that by having my registration become effective before the beginning of the renewal period (April 1) my license will not be valid for a full year.**
- [] I wish to have my registration become effective on the following April 1. (ONLY APPLICABLE FOR NEW OUTLETS)

As the consultant pharmacist for this hospital, I am responsible for this hospital complying with all applicable State and Federal Laws and Rules governing the practice of Pharmacy. A copy of my current pharmacist certificate is displayed in the drug room.

Signature of Consulting Pharmacist: _____ Date _____

Printed name: _____ License # _____

MAIL THIS APPLICATION WITH REQUIRED DOCUMENTS, AND FEE, PAYABLE TO THE OREGON BOARD OF PHARMACY.

ALL RETURNED CHECKS WILL BE ASSESSED A \$35.00 RETURNED CHECK FEE PURSUANT TO ORS 30.701(5)

APPLICATION FOR REGISTRATION

APPLICATION FOR REGISTRATION UNDER OREGON CONTROLLED SUBSTANCE ACT (Expires March 31 Annually)

OREGON BOARD OF PHARMACY 800 NE OREGON STREET, SUITE 150 PORTLAND OR 97232 TELEPHONE (971) 673-0001 www.pharmacy.state.or.us



FOR BOARD USE ONLY [0310] \$50.00 RECEIPT # BATCH DATE ENTERED BY

CONTROLLED SUBSTANCE

FEE \$50.00 ALL FEES ARE NON REFUNDABLE

The Controlled Substance registration is not an independent registration, it must be issued in conjunction with a Hospital Drug Room Registration. (If Not Applicable, please check here) []

Please PRINT or TYPE

WARNING: ORS 475.135 (e) The furnishing of false information is grounds to deny registration.

Business Name

Location Address

Phone Number () - FAX # () -

City, State, Zip

License & Renewal Mailing Address

Contact Person Title Contact Phone

City, State, Zip

Phone Number () - FAX # () -

Federal Tax ID # or Owner SSN: Does this outlet belong to a chain? [] Yes [] No

DRUG SCHEDULES (Check appropriate box(es))

[] Schedule I [] Schedule II [] Schedule III [] Schedule III [] Schedule IV [] Schedule V

Attach list of stocked Schedule I Drugs [] Narcotic [] Non-Narcotic

ALL APPLICANTS MUST ANSWER THE FOLLOWING:

1. Are you currently registered to manufacture, distribute or otherwise handle the controlled substances in the schedules for which you are applying under the laws of the Federal Government? [] YES [] NO

CURRENT FEDERAL REGISTRATION NUMBER

2. Has the applicant been convicted of a felony in connection with controlled substances under state or federal law? [] YES [] NO

3. If the applicant is a corporation, association or partnership, has any officer, partner or stockholder been convicted of a felony in connection with controlled substances under state or federal law? [] YES [] NO

4. Has the applicant ever surrendered a previous Federal Controlled Substances Registration (FCSA) or had a FCSA Registration revoked, suspended or denied? [] YES [] NO

5. If the applicant is a corporation, association or partnership, has any officer, partner, or stockholder surrendered a FCSA Registration or had a FCSA Registration revoked, suspended or denied? [] YES [] NO

IF THE ANSWER IS YES TO ANY OF QUESTIONS 2 THROUGH 5, ATTACH LETTER SETTING FORTH THE CIRCUMSTANCES.

Print or Type Name of Applicant Signature of Applicant or Authorized Individual Date

MAIL THIS APPLICATION WITH REQUIRED DOCUMENTS, AND FEES, PAYABLE TO THE OREGON BOARD OF PHARMACY.

ALL RETURNED CHECKS WILL BE ASSESSED A \$35.00 RETURNED CHECK FEE PURSUANT TO ORS 30.701(5)