

**Supplemental Information Form
Consulting or Drugless Pharmacy**

**Oregon Board of Pharmacy
800 NE Oregon St., Suite 150
Portland, Oregon 97232**

Please complete BOTH columns of this required form and return with your renewal form. This form will be used to update your file.

Business Name: _____
Physical Location Address: _____
City, State, Zip _____
IS THIS THE PRIMARY MAILING ADDRESS FOR LICENSE & RENEWALS?
____ YES ____ NO (If no, please complete mailing address below)
Mailing Address _____
City, State, Zip _____

License Number: _____
Phone / Fax Number: _____
Federal Tax ID Number: _____
Contact Name: _____
Contact Number: _____
Contact E-mail: _____

PLEASE FILL IN THE APPROPRIATE INFORMATION UNDER ITEM 1, 2 OR 3, RELATING TO OWNERSHIP.

1 Individual Owner, Trustee or Receiver:

Title: _____
City, State, Zip: _____

Name: _____
Address _____

2 Partnership - List Name - Address of all Partners: (Attach a separate sheet if more space is needed.)

Name: _____ Address: _____

3 Corporation or LLC: (List name & address of President and Vice President or Members.)

(Please list Inc., Corp., LLC, etc.)

Address: _____

Corporate or LLC Name: _____
President: _____
Vice President: _____
Member(s): _____
State in which Incorporated: _____

Staffing Information
Consulting or Drugless Pharmacy

Please list all pharmacists that work at or monitor the facility, as well as all technicians and other staff that work at the facility.
This form may be duplicated as needed.

1. _____

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