

**Supplemental Information Form
Hospital Drug Room**

**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: _____
DEA Number: _____
Phone / Fax Number: _____
Federal Tax ID Number: _____
Contact Person: _____
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:

Name: _____
Address: _____

Title: _____
City, State, Zip: _____

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 Member(s).

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

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

Address: _____

Consulting Pharmacist
Hospital Drug Room

855-041-6800 formerly 855-041-0135 Supervision of Consulting Pharmacist

(1) In a hospital having a drug room and no pharmacy, the drug room must be supervised by a licensed pharmacist who provides his or her services with sufficient professionalism, quality and availability to adequately protect the safety of the patients and to properly serve the needs of the facility. the arrangements for a consulting pharmacist shall be in writing, and shall, at a minimum, provide that:

- (a) The pharmacist is to act in the capacity of a part-time director;
- (b) The pharmacist shall provide on-call service at all times;
- (c) Adequate storage facilities for drugs will be provided; and
- (d) All drugs supplies shall be labeled so as to insure that recalls can be effected and that proper control and supervision of such drugs may be exercised.

SIGNATURE OF CONSULTANT PHARMACIST

DATE

FIRST AND LAST NAME OF CONSULTANT PHARMACIST

CONSULTANT PHARMACIST EMAIL ADDRESS FOR BOARD USE

Oregon Pharmacist

License Number: _____

Oregon Outlet

License Number: _____

***The pharmacist signing this document acknowledges reading and understanding
the responsibilities of a consultant pharmacist.***