

APPLICATION FOR REGISTRATION

COMMUNITY HEALTH CLINIC

(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 [0312] \$75.00

RECEIPT # _____

CHECK # _____

ENTERED BY _____

COMMUNITY HEALTH CLINIC

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.

Clinic Name _____

Location Address _____

Phone Number () - FAX # () -

City, State, Zip _____

License & Renewal Mailing Address _____

City, State, Zip _____

Contact Person _____ Title _____ Contact Phone _____

Federal Tax ID # _____ Email Address: _____

Designated Representative _____

Medical Director _____ License Number _____

Registered Nurse _____ License Number _____

Hours/days clinic is open: _____ AM to _____ PM _____ Through _____

Hours/days clinic is open: _____ AM to _____ PM. _____ Through _____

As the Medical Director, I am responsible for this clinic's compliance with applicable State and Federal Laws and Rules.

[] I certify that we have written policies and procedures for drug management, including security, acquisition, storage, dispensing and drug delivery, disposal, and record keeping

[] I certify that all drugs will be kept in a locked drug cabinet or designated drug storage area that is sufficiently secure to deny access to unauthorized persons. The drug cabinet or designated drug storage area will remain locked and secured when not in use.

[] I certify that all drugs are acquired from a registrant of the Board.

Signature of Medical Director _____

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)