

**Supplemental Information Form
Charitable 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: _____
DEA Number: _____
Phone / Fax Number: _____
Federal Tax ID Number: _____
Point of 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:

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: (List name & address of President, Vice President and Secretary.)

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

Corporate Name _____
President _____
Vice President _____
Secretary/Treasurer _____
State in which incorporated _____

Address _____

**Point of Contact
Charitable Pharmacy**

NAME: _____

ADDRESS: _____

CITY, STATE ZIP _____

PHONE NUMBER: _____

FAX: _____

EMAIL ADDRESS: _____

SIGNATURE OF POINT OF CONTACT

DATE

FIRST AND LAST NAME OF POINT OF CONTACT

The person of contact signing this document acknowledges reading and understanding the Charitable Pharmacy Rules as defined in OAR Division 44 and the requirement to comply with Oregon's Laws and Rules.