

**2016 WHOLESALER RENEWAL
SUPPLEMENTAL INFORMATION FORM**



Oregon Board of Pharmacy
800 NE Oregon Street, Suite 150
Portland OR 97232

Please PRINT or TYPE **WARNING:** ORS 475.135(1)(e) and ORS 689.405(1) The furnishing of false information is grounds to deny registration.

Business Name (DBA) _____

Corporation Name _____

Parent Company Name (if applicable) _____

License Number _____ Federal Tax ID # _____

Location Address _____

City, State, Zip _____

Phone Number (____) _____ - _____ FAX # (____) _____ - _____

Licensing Contact Person _____ Title _____ Contact Phone _____

Email Address: _____

Is the address listed above the primary mailing address for license and renewals? [] Yes [] No

If No, please complete the mailing information below:

Mailing Address _____

City, State, Zip _____

Officers or Members Information

Complete this section for Corporate Officers or Members. You may provide an attachment with this information.

1. Name _____

Title _____

Address _____

City, State, Zip _____

Phone Number _____

Email Address _____

2. Name _____

Title _____

Address _____

City, State, Zip _____

Phone Number _____

Email Address _____

Designated Representative or Contact Representative of Facility

Please complete ONE of the following. If you are a Class I Wholesaler complete the Designated Representative information. If you are a Class II Wholesaler, Class III Wholesaler or a Third-Party Logistics Provider, complete the Contact Representative information.

If you are also providing Third Party Logistics (3PL) services, you will need to register and hold a Drug Distribution Agent registration. This is in addition to the Wholesaler registration you are renewing.

Designated Representative Information:

FOR WHOLESALER CLASS I OUTLETS ONLY

Full Name _____

Street Address _____

City, State, Zip _____

Phone Number _____

Fax _____

Email Address _____

Normal Business Hours of Facility _____

Contact Representative Information:

FOR WHOLESALER CLASS II, & III OUTLETS,

Full Name _____

Street Address _____

City, State, Zip _____

Phone Number _____

Fax _____

Email Address _____

Normal Business Hours of Facility _____

Attestation and Signature

Please Select the Applicable Classification for your Registered Facility

Class I Wholesaler - Distributes any of the following:

- Prescription Drugs;
- Controlled Substances;
- Devices Containing Prescription Drugs;
- Medicinal Chemicals; or
- Poisons
- Note: A registered Class I Wholesaler may distribute Non-Prescription Drugs with this registration.

If you are a Class I Wholesaler, please check one of the following items and submit the required documents listed below along with your renewal application.

This facility is **VAWD Accredited** through the **NABP, or the accreditation is currently pending.**

-OR-

We are located in Oregon; or we are a non-resident facility that has been inspected within the last three years by a state whose inspection report has been approved by the Oregon Board of Pharmacy.

Yes **No** . The Designated Representative (DR) is the DR for this facility only and is aware of the daily operations, and is physically present during normal business hours.

Class II Wholesaler . Does not distribute Controlled Substances and only distributes the following:

- Non-Prescription Drugs

Class III Wholesaler (NEW CLASSIFICATION) – Distributes any of the following:

- Drugs for Veterinary use;
- Prescription Devices that do not contain Prescription Drugs;
- Oxygen USP and Medical Gases;
- Intravenous Drugs; or
- Medical Convenience Kits

-OR-

Is a State or Local Government Agency, or a Non-Profit Relief Organization approved by the Board;

Third-Party Logistics Provider (3PL)

Yes **No** . Our company provides logistics services for a product in interstate commerce on behalf of a manufacturer, wholesale distributor, or dispenser of a product, but does not take ownership of the product, and does not have responsibility to direct the sale or disposition of the product.

Our company is also a Third-Party Logistics Provider and is currently registered as a Drug Distribution Agent.

Our company is also a Third-Party Logistics Provider and will submit a registration application for a Drug Distribution Agent.

Yes **No** . Prior to distributing or shipping product into or within Oregon, we verify the entity is licensed in Oregon.

Yes **No** . We are aware that all wholesalers must complete a self inspection report by September 1st annually. This report must be retained at the facility and made available upon request. This form is available at www.pharmacy.state.or.us.

Yes **No** - Since the date of your last renewal has **disciplinary action** been taken, or is any such action currently pending against any of the persons or establishments listed on this application, by any State or Federal Authority in connection with a violation of any federal or state drug law or regulation? If ~~yes~~, attach a copy of the Board Order if applicable, a detailed explanation of the incident and describe any penalty incurred.

The undersigned hereby states that all the information contained in this application for renewal is true and correct, that they have read and are familiar with the pharmacy laws and rules of the Oregon Board of Pharmacy, and that such provisions of the law will be faithfully observed.

Print or Type Name

Signature

Date