2021
Community Health Clinic
Supplemental Information Form

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

You must complete ALL fields of this required form and return with your payment. This form will be used to update your record.

All information is required. You must complete both sides of this form.

Drug Outlet License Number: _____
Clinic Name (DBA) _____
Owner, Corp or LLC Name: _____
Federal Tax ID Number:

Physical Location Address: _____
City, State, Zip: _____
Phone / Fax Number:

Designated Representative: _____
Designated Representative Email: _____

Medical Director: _____

Dispensing Registered Nurse: _____
Dispensing RN License No: _____
(Attach additional list if necessary)

IS THIS THE PRIMARY MAILING ADDRESS FOR LICENSE & RENEWALS?

_____YES _____NO
Mailing Address: _____
City, State, Zip:

(If no, please complete mailing address below)

Licensing Contact Person: _____
Licensing Contact Number: _____
Licensing Contact E-mail:

PLEASE FILL IN THE APPROPRIATE OWNERSHIP INFORMATION.

Please provide the name, title, address, and email of the Owner, CEO, President, Partners, or Members of LLC.

Name & Title: _____
Address: _____
City, State, Zip: _____
Email: _____

Name & Title: _____
Address: _____
City, State, Zip: _____
Email: _____

Name & Title: _____
Address: _____
City, State, Zip: _____
Email: _____

Name & Title: _____
Address: _____
City, State, Zip: _____
Email: _____

State in which Incorporated: _____

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FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY WILL CONSTITUTE AN INCOMPLETE ANNUAL RENEWAL APPLICATION.

[ ] Yes [ ] No Before purchasing a drug from any distributor, do you verify that the vendor is legally authorized to sell the drug?
Go to https://orbop.mylicense.com/verification/ to verify active registration.

[ ] Yes [ ] No Are all registered nurses that will dispense drugs licensed / registered appropriately with their healthcare board?

[ ] Yes [ ] No* Policies and procedures for this outlet have not changed or if changed, have been reviewed and approved since last renewal.
* If **"no"**, attach the new or updated policies and procedures for review and approval. See CHC application on the Board's website for submission requirements.

[ ] Yes [ ] No Our Annual Self-Inspection form has, or will be completed by February 1 per OAR 855-043-0710(2)(a)?
Self-Inspection Forms can be found on the Board's website.

[ ] Yes * [ ] No Since the date of your last renewal has any investigation been initiated, or has any pharmacy or drug related disciplinary action been taken, or is any such action currently pending against any of the persons or facilities listed on this renewal application by any State (other than Oregon) or Federal Authority?

***** If **"yes"**, attach a copy of the Board order if applicable, include a detailed explanation of the incident below, and describe any pending discipline or penalty incurred.

SIGNATURE OF AUTHORIZED PERSON

DATE

PLEASE PRINT FIRST AND LAST NAME

TITLE