2022
Charitable Pharmacy
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 file.

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

Drug Outlet License Number: CP-
Pharmacy Name (DBA):
Owner, Corp or LLC Name:
Federal Tax ID Number:

Point of Contact Name:
Title:
Phone:
Email:

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

IS THIS THE PRIMARY MAILING ADDRESS FOR LICENSE & RENEWALS?
_____YES _____NO **(If no, please complete mailing address below)**
Mailing Address:
City, State, Zip:

DEA Number (If Applicable):
(Required if you hold an Oregon Controlled Substance Registration)

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 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.

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SIGNATURE OF AUTHORIZED PERSON	DATE
PLEASE PRINT FIRST AND LAST NAME	TITLE