

2022
Consulting or Drugless 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: | CON- |
| Pharmacy Name (DBA): | |
| Owner, Corp or LLC Name: | |
| Federal Tax ID Number: | |

| | |
|-----------------------------|------|
| Pharmacist In Charge (PIC): | |
| Oregon RPh License #: | RPH- |
| Date Became PIC (MM/YY): | |

| | |
|--|--|
| Physical Location Address: | |
| City, State, Zip: | |
| Phone / Fax Number: | |
| IS THIS THE PRIMARY MAILING ADDRESS FOR LICENSE & RENEWALS? | |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO (If no, please complete mailing address below) |
| Mailing Address: | |
| City, State, Zip: | |

| | |
|---------------------------|--|
| Licensing Contact Person: | |
| Licensing Contact Phone: | |
| 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: | | Name & Title: | |
| Address: | | Address: | |
| City, State, Zip: | | City, State, Zip: | |
| Email: | | Email: | |
| Name & Title: | | Name & Title: | |
| Address: | | Address: | |
| City, State, Zip: | | City, State, Zip: | |
| Email: | | Email: | |
| State in which Incorporated: | | | |

2022
Consulting or Drugless Pharmacy
Staffing Information:

**FAILURE TO COMPLETE THIS FORM IN ITS
ENTIRETY WILL CONSTITUTE AN
INCOMPLETE ANNUAL RENEWAL
APPLICATION. THIS FORM MAY BE
DUPLICATED AS NEEDED.**

Staffing Information:

Please list all pharmacists that work at or monitor the facility, as well as all technicians and other staff that work at the facility.

- | | |
|----------|-----------|
| 1) _____ | 9) _____ |
| 2) _____ | 10) _____ |
| 3) _____ | 11) _____ |
| 4) _____ | 12) _____ |
| 5) _____ | 13) _____ |
| 6) _____ | 14) _____ |
| 7) _____ | 15) _____ |
| 8) _____ | 16) _____ |

[] Yes [] No* Do the current policies and procedures include at a minimum:

- (1) A policy on protecting confidentiality and integrity of patient information;
- (2) An outline of responsibilities and scope of services;
- (3) A policy on compliance with federal and state laws and rules;
- (4) An operational Quality Assurance Program;
- (5) A policy that describes use of computer systems.

[] 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
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