

2020
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? ____YES ____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:	
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: _____

2020
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. NOTE: A technician may not work remotely.

- | | |
|-----------|-----------|
| 1) _____ | 11) _____ |
| 2) _____ | 12) _____ |
| 3) _____ | 13) _____ |
| 4) _____ | 14) _____ |
| 5) _____ | 15) _____ |
| 6) _____ | 16) _____ |
| 7) _____ | 17) _____ |
| 8) _____ | 18) _____ |
| 9) _____ | 19) _____ |
| 10) _____ | 20) _____ |

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 Consulting/Drugless pharmacy application on the Board's website for submission requirements.

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

SIGNATURE OF AUTHORIZED PERSON

DATE

PLEASE PRINT FIRST AND LAST NAME

TITLE
Page 2 of 2



Oregon

Kate Brown, Governor

Oregon Board of Pharmacy
800 NE Oregon Street, Suite 150
Portland, OR 97232
Phone: 971 / 673-0001
Fax: 971 / 673-0002

E-mail: pharmacy.licensing@state.or.us

Web: www.oregon.gov/pharmacy

CONSULTING OR DRUGLESS PHARMACY ANNUAL REPORT 2019 DATA

Please answer the following questions and return with your 2020 Supplemental Information Form and annual renewal payment. Additional attachments may be provided.

1. Please list your pharmacy business name: _____

2. Please list your consulting pharmacist(s): _____

3. Approximately how many patients residing outside of Oregon did your pharmacy provide pharmacy services to during the 2019 calendar year?

4. Please list the top three clinical conditions of your patient population. (For example: mental health, cardiovascular disease, diabetes, pain, etc.)

5. Are there any rule changes or procedures that you would like the Board to consider? Are there any current rules you have found to be problematic? Please explain.