APPLICATION FOR REGISTRATION

CORRECTIONAL FACILITY DRUG OUTLET

(Expires March 31 Annually)

APPLICATION REQUIREMENTS:	
$140.00 application or owner/location change fee / $280.00 if dispensing or handling controlled substances - All fees are non-refundable. **Controlled substance application* & copy of active DEA registration** *If facility does not handle controlled substances, box indicating "Not Applicable" must be marked. **If you answer "YES" to any disciplinary action questions,** including pending disciplinary actions, all notices, citations, etc. and fully executed Board orders must be provided along with a detailed explanation. ***Priority processing will be given to complete applications.** All applications submitted to the Board that are not complete and processed within 6 months will be expired. Once expired, applicants who wish to continue with the application process must reapply by submitting a new application, along with all documentation, and all fees.	
Mail completed application and all required documentation to: Oregon Board of Pharmacy 800 NE Oregon Street, Suite 150 Portland OR 97232	**Questions? Contact us:** Telephone: (971) 673-0001 www.oregon.gov/pharmacy pharmacy.licensing@bop.oregon.gov

Please read the following instructions for applicants for registration as a Correctional Facility Drug Outlet.

1. Oregon Administrative Rule Chapter 855, Division 043 (OAR 855-043-0630) contains additional information and requirements regarding the Correctional Facility registration.

2. The Board will issue a registration once all required documentation and fee(s) have been submitted and the application is approved. An outlet may not commence business in Oregon until a registration is issued.

3. Each company or location address, even if under common ownership, must submit a separate application for registration.

4. You must pay a registration fee for each application for **a New Registration, an Ownership Change or a Location Change**. The Board can only accept payment by check or money order. **All fees are non-refundable.**

   Examples of a required ownership change application include but are not limited to: corporate restructure; LLC to a Corporation, Corporation to LLC; acquisition of assets; or additions or deletions of an owner. An ownership change requires submission of a copy of the sales agreement or other documentation that verifies proof of new ownership.

   If you are completing these forms to report a **Name Change** only, you do not pay a fee.

5. **Oregon Controlled Substance Registration**. The Controlled Substance Registration is required for all outlets that dispense controlled substances. Be advised that the Controlled Substance Registration is not an independent registration. It must be issued in conjunction with a Drug Outlet Registration.

Applications will not be processed without the completion of the Controlled Substance Application. **You must submit a copy of your DEA registration along with your application.** If your facility does not handle controlled substances, please check the box "Not Applicable" and return it with the Application. Note: The controlled substance fee is **not** required if the application is marked "Not Applicable."

6. Oregon law **requires** each Consultant Pharmacists to conduct an annual self-inspection by completing a self-inspection report by ***July 1st*** annually.

   The self-inspection report form is available on the Board's website. This form needs to be completed and available for inspection by the Board at all times. The purpose of the self-inspection is to ensure the correctional facility is in compliance with state and federal laws and rules governing the drug outlet.

7. **Oregon Revised Statues and Administrative Rules** are accessible on our website at: https://www.oregon.gov/pharmacy/Pages/Laws-Rules.aspx. You may purchase a set for $25 (check the box on the application if you wish to purchase one or more sets).

Your registration is to be in your possession *PRIOR* to dispensing drug products in Oregon.

Correctional Facility Drug Outlet registrations expire March 31 annually and fees are not prorated. Renewal notices will be mailed out mid-January.

APPLICATION FOR REGISTRATION

CORRECTIONAL FACILITY DRUG OUTLET

(Expires March 31 Annually)
Oregon Board of Pharmacy
800 NE Oregon Street, Suite 150
Portland OR 97232
pharmacy.licensing@bop.oregon.gov

FOR BOARD USE ONLY

[0309] $140.00
[0310] $140.00
[0326] $ 25.00

RECEIPT # _____
CHECK # _____
ENTERED BY _____
PERSON ID # _____
APPLICANT ID # _____

Please check all that apply:

☐ **Correctional Facility Drug Room (with/without controlled substances)** **Fee: $140.00**
☐ **Controlled Substance Registration** **Fee: $140.00**
☐ **Laws & Rules per set, please indicate quantity_____** **Fee: $ 25.00**

TOTAL ENCLOSED:_____
ALL FEES ARE NON-REFUNDABLE

Type of Application – Check all that apply:

☐ **New Facility Application - Start / Effective Date:** _____

☐ **Change of Ownership or** ☐ **Location Change – Effective Date of Change:**_____
A change of ownership or location **requires** the submission of a new application and registration fee **within 15 days**.

Registration Number: _____

☐ **Legal documentation of the change in ownership or control, for example, a stock purchase agreement and/or and executed contract for sale, etc.**

☐ **Registration Reinstatement (Registration has been lapsed for a period of one year or more)**

Registration Number: _____

☐ **Name Change Only (No fee required)**

Registration Number: _____

Please PRINT or TYPE

WARNING: ORS 689.405(1) The furnishing of false information is grounds to deny registration.

Trade or Business Name (DBA): _____

Full Legal / Owner Name:_____

Federal Tax ID # or Owner SSN: _____NABP eProfile #_____

Physical Location Address:_____

City:_____State:_____Zip:_____

Phone Number: _____FAX # _____

Registration & Renewal Mailing Address: _____

City, State, Zip: _____

Licensing Contact Person:_____Title_____Contact Phone_____

Licensing Contact Person E-mail Address: _____

Hours / Days Establishment is open: _____AM to _____PM _____Through_____

Consultant Pharmacist Name:_____License No:_____

Registered Nurse: _____ License No:_____

Nurse Practitioner: _____ License No:_____

Health Officer: _____ License No:_____

Please answer all of the following:

1. Has disciplinary action been taken, or is any such action currently pending or proposed 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 detailed explanation of the incident and describe any penalty incurred. You must provide a copy of all documents pertaining to discipline. This includes Notice of Disciplinary Actions, Board Orders and other related documents.	☐Yes ☐ No
2. Are all dispensing practitioners that will dispense drugs are registered appropriately with their licensing board?	☐Yes ☐No
3. Is this facility a small business? A small business is defined as a corporation, partnership, sole proprietorship or legal entity, which is independently owned and operated from all other businesses and which has 50 or fewer employees?	☐Yes ☐No
4. This facility dispenses controlled substances. If "yes", you must fully complete pages 4 & 5 of this application. *Oregon Schedules of Controlled Substances may be found at:* https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=3987 *and may be different from the Federal schedules. You must comply with the most stringent.*	☐Yes ☐No

As the consultant pharmacist for this correctional facility's drug room, I am responsible for this facility complying with all applicable State and Federal Laws and Rules governing the practice of Pharmacy. A copy of my current pharmacist certificate is displayed in the drug room.

I also understand that under ORS 689.405(1) the furnishing of any false information is grounds for denial of registration.

Print Name of Consultant Pharmacist	Signature of Consultant Pharmacist	Date

Ownership Information

Type of Ownership:

☐ Publicly Held Corporation ☐ Corporation ☐ Limited Liability Company ☐ Sole Proprietorship

☐ Partnership – Including Limited Liability Partnership and Limited Partnership ☐ Charitable Organization

☐ Government / Educational Institution

Owner Name _____

Parent Company Name (If owned by another entity) _____

Complete the information below for all owners. You must include the Registered Agent and at least one of the following: CEO, President, Owner, or Members of LLC. If a corporation, include the names of the corporate officers and the names of the stockholders who own the five largest interests.

1. Name _____

Title _____

SSN/Federal Tax ID _____

Address _____

City, State, Zip _____

Phone Number _____

Email Address _____

2. Name _____

Title _____

SSN/Federal Tax ID _____

Address _____

City, State, Zip _____

Phone Number _____

Email Address _____

3. Name _____

Title _____

SSN/Federal Tax ID _____

Address _____

City, State, Zip _____

Phone Number _____

Email Address _____

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CONTROLLED SUBSTANCE APPLICATION
APPLICATION FOR REGISTRATION UNDER
OREGON CONTROLLED SUBSTANCE ACT

OREGON BOARD OF PHARMACY
800 NE OREGON STREET, SUITE 150
PORTLAND OR 97232
pharmacy.licensing@bop.oregon.gov

FOR BOARD USE ONLY [0310] $140.00

RECEIPT # _____

CHECK # _____

PERSON ID # _____

CONTROLLED SUBSTANCE APPLICATION FEE $140.00 ***ALL FEES ARE NON-REFUNDABLE***

Type of Application – Check all that apply:

☐ **Not Applicable. This facility does not handle or distribute Controlled Substances.**

☐ **This is a new registration**

☐ **This is a change in owner or location.**

☐ **I wish to add a Controlled Substance registration to my existing facility.**

Oregon Registration Number: _____

☐ **I wish to reinstate a Controlled Substance registration to my existing facility.**

Oregon Registration number: _____

Please PRINT or TYPE

WARNING: ORS 475.135 (1)(e) The furnishing of false information is grounds to deny registration.

Trade or Business Name (DBA): _____

Full Legal / Owner Name: _____

Federal Tax ID # or Owner SSN: _____

Physical Location Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ FAX # _____

Registration & Renewal Mailing Address: _____

City, State, Zip: _____

Licensing Contact Person: _____ Title _____ Contact Phone _____

Licensing Contact Person E-mail Address: _____

DRUG SCHEDULES (Check appropriate box(es):

☐ Schedule I ☐ Schedule II ☐ Schedule II N ☐ Schedule III ☐ Schedule III N ☐ Schedule IV ☐ Schedule V

Attach a list of stocked Schedule I Drugs: [ ] Narcotic [ ] Non-Narcotic

APPLICANTS FOR A CONTROLLED SUBSTANCE REGISTRATION MUST ANSWER THE FOLLOWING:

1. Are you currently registered to dispense or otherwise handle the controlled substances in the schedules for which you are applying under the laws of the Federal Government?	☐Yes ☐ No
2. Have any of the persons or establishments listed on this application been convicted of a felony in connection with controlled substances under state or federal law?	☐Yes ☐No
3. If the applicant is a corporation, association or partnership, has any officer, partner or stockholder been convicted of a felony in connection with controlled substances under state or federal law?	☐Yes ☐No
4. Have any of the persons or establishments listed on this application ever surrendered a previous Federal Controlled Substances Registration (FCSA) or had a FCSA Registration revoked, suspended or denied?	☐Yes ☐No
5. If the applicant is a corporation, association, or partnership, has any officer, partner, or stockholder surrendered a FCSA Registration or had a FCSA Registration revoked, suspended or denied?	☐Yes ☐No
IF THE ANSWER IS YES TO ANY OF QUESTIONS 2 THROUGH 5, YOU MUST ATTACH A LETTER SETTING FORTH THE CIRCUMSTANCES.	
CURRENT FEDERAL REGISTRATION NUMBER _____ (You must submit a copy of your DEA registration along with this application.)	

Print or Type Name of Authorized Individual _____ Signature of Authorized Individual _____ Date _____

Facility Attestation Form

Part 1 – Responsible Party Information - To be completed by an authorized individual of the applicant. This must be an individual who may legally sign on behalf of the business and is responsible for compliance with Oregon Laws and Rules.

First Name:_____ Last Name:_____

Title:_____

Contact email:_____

Facility Name:_____

Facility Address:_____

Facility City, State, Zip:_____

Part 2 – Attestation - To be completed by the responsible party listed above (person who may legally sign for the business). *Must be manually signed in ink.*

Per Oregon Revised Statue 689.405(1) The furnishing of false information is grounds to deny registration.

I swear or affirm that all information, statements, answers, and representations made in this application and the documents attached are true and correct, that the individuals at this facility are familiar with the laws and rules of the Oregon Board of Pharmacy as well as applicable federal laws, and that the business will be operated in compliance with all applicable laws and regulations.

Signature:_____ Date:_____

Printed Name:_____

FINAL CHECKLIST:	
1.	Appropriate Fee Included?
☐ $140.00 application or owner/location change fee ☐ $140.00 Controlled Substance application or owner/location change fee (if applicable) **Total Fee Enclosed: _____**	
2.	Required Documentation* – an application is incomplete if all requested documentation is not provided. *Priority processing will be given to complete applications. All applications submitted to the Board that are not complete and processed within 6 months will be expired. Once expired, applicants who wish to continue with the application process must reapply by submitting a new application, along with all documentation, and all fees.
B.	☐ If you answer "YES" to any disciplinary questions; disciplinary actions, pending disciplinary actions, and fully executed Board orders must be provided along with a detailed explanation**.**
C.	☐ Copy of active DEA registration, if applicable
D.	☐ Completed Facility Attestation Form
E.	☐ All signatures

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

_____	_____	_____
Signature	Title (Owner, Partner, Etc.)	Date

ALL RETURNED PAYMENTS WILL BE ASSESSED A $35.00 RETURNED PAYMENT FEE PURSUANT TO ORS 30.701(5)