

**2022**  
**Home Dialysis Drug Outlet**  
**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:	_____
Pharmacy Name (DBA):	_____
Owner, Corp or LLC Name:	_____
Federal Tax ID Number:	_____

Pharmacist In Charge (PIC):	_____
PIC License Number:	_____
PIC Start Date (MM/YY)	_____

Physical Location Address:	_____
City, State, Zip:	_____
Phone / Fax Number:	_____
<b>IS THIS THE PRIMARY MAILING ADDRESS FOR LICENSE &amp; RENEWALS?</b>	
____ YES    ____ NO    (If no, please complete mailing address below)	
Mailing Address:	_____
City, State, Zip:	_____

Name of Remote Processing Pharmacy Affiliate:	_____
(If Applicable)	_____
Pharmacy License Number:	_____
Pharmacy Address:	_____
City, State, Zip	_____

Contact Person:	_____
Contact Number:	_____
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:	_____
State in which Incorporated:	_____

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

