

**Supplemental Information Form
Remote Distribution Facility**

**Oregon Board of Pharmacy
800 NE Oregon St., Suite 150
Portland, Oregon 97232**

Please complete BOTH columns of this required form and return with your renewal form. This form will be used to update your file.

Business Name: _____
Physical Location Address: _____
City, State, Zip _____
IS THIS THE PRIMARY MAILING ADDRESS FOR LICENSE & RENEWALS?
____ YES ____ NO (If no, please complete mailing address below)
Mailing Address _____
City, State, Zip _____
Responsible Pharmacy: _____
Pharmacy License No. _____

License Number: _____
DEA Number: _____
Phone / Fax Number: _____
Federal Tax ID Number: _____
Contact Name: _____
Contact Number: _____
Contact E-mail: _____
Pharmacy Address: _____

PLEASE FILL IN THE APPROPRIATE INFORMATION UNDER ITEM 1, 2 OR 3, RELATING TO OWNERSHIP.

1 Individual Owner, Trustee or Receiver:

Name: _____
Address: _____

Title: _____
City, State, Zip: _____

2 Partnership - List Name - Address of all Partners: (Attach a separate sheet if more space is needed.)

Name: _____

Address: _____

3 Corporation or LLC: (List name & address of President and Vice President or Members.)

(Please list Inc., Corp., LLC, etc.)

Corporate or LLC Name: _____
President: _____
Vice President: _____
Member(s): _____
State in which Incorporated: _____

Address: _____

Staffing Information
Remote Distribution Facility

Please list all pharmacists that work at or monitor the facility, as well as all technicians and other staff that work at the facility.
This form may be duplicated as needed.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

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11. _____

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19. _____

20. _____