

**Supplemental Information Form  
Retail or Institutional Drug Outlet**

**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.

**All information is required. Please complete all lines below.**

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: \_\_\_\_\_

License Number: \_\_\_\_\_  
DEA Number (If Applicable) \_\_\_\_\_  
Phone / Fax Number: \_\_\_\_\_  
Federal Tax ID Number: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Contact Number: \_\_\_\_\_  
Contact E-mail: \_\_\_\_\_

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 Member(s).

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

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

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# 2016 Required Questions

*Please Note: Magic mouth wash or the mixing of two creams are not applicable to questions 1-3.*

**1) What type of medications do you compound? Please check all that apply.**

- This facility does not compound medications.
- Non-Sterile
- Non-Sterile to Sterile
- Sterile to Sterile (IV, Parenteral or Re-Packaging)

**FAILURE TO COMPLETE THIS FORM  
IN ITS ENTIRETY WILL CONSTITUTE  
AN INCOMPLETE ANNUAL RENEWAL  
APPLICATION.**

**2) Who do you compound medications for? Please check all that apply.**

- Patients, pursuant to a prescription
- Practitioners, non-patient specific
- Facilities/Institutions, non-patient specific

**3) Describe the dosage form for which you compound. Please check all that apply.**

- Solids
- Liquids
- Parenteral
- Other - please describe: \_\_\_\_\_

**4)  Yes  No Are you a 503B Outsourcing Facility?**

**5)  Yes  No Since the date of your last renewal has disciplinary action been taken, or is any such action currently pending against any of the persons or facilities 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.**

*The pharmacist signing this document acknowledges reading and understanding the responsibilities of a Pharmacist-In-Charge.*

\_\_\_\_\_  
SIGNATURE OF OREGON LICENSED PHARMACIST-IN-CHARGE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PLEASE PRINT FIRST AND LAST NAME

\_\_\_\_\_  
OREGON PHARMACIST LICENSE NUMBER