APPLICATION FOR REGISTRATION

CORRECTIONAL FACILITY DRUG OUTLET
(Expires March 31 Annually)

OREGON BOARD OF PHARMACY
800 NE OREGON STREET, SUITE 150
PORTLAND, OR 97232
TELEPHONE: (971) 673-0001
www.pharmacy.state.or.us

CORRECTIONAL FACILITY

Fee: $75.00
ALL FEES ARE NON REFUNDABLE

[ ] New Outlet Start Date __________________________
[ ] Owner Change Date Effective __________________ Former license number __________
[ ] Location Change Date Effective ________________ Former license number __________

A change of ownership or location requires the submission of a new application and registration fee within 15 days. Please check the appropriate box regarding application status:
[ ] Name change only (no fee required)

Please PRINT or TYPE

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

Institution Name __________________________________________
Location Address __________________________________________
Phone Number ( ) - _______________ FAX # ( ) - _______________
City, State, Zip __________________________________________
License & Renewal Mailing Address __________________________
City, State, Zip __________________________________________
Contact Person ____________________________________________ Title __________________ Contact Phone ______________
Federal Tax ID # __________________________ Email Address: __________________________

[ ] I wish to have my registration application processed on the date you receive my COMPLETE APPLICATION and PAYMENT in your office. Because the Oregon Board of Pharmacy does not prorate fees, I realize that by having my registration become effective before the beginning of the renewal period (April 1) my license will not be valid for a full year.

[ ] I wish to have my registration become effective on the following April 1st. (ONLY APPLICABLE FOR NEW DRUG OUTLETS)

Registered Nurse __________________________________________
Nurse Practitioner __________________________________________
Health Officer _____________________________________________
Consultant Pharmacist __________________________ RPh License # ______________
Hours of Operation _________________________________________

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.

Signature of Consultant Pharmacist __________________________ Date ______________

MAIL THIS APPLICATION WITH REQUIRED DOCUMENTS, AND FEES, PAYABLE TO THE OREGON BOARD OF PHARMACY.

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

Revised July 1, 2013
APPLICATION FOR REGISTRATION UNDER OREGON CONTROLLED SUBSTANCE ACT
(Expires March 31 Annually)

OREGON BOARD OF PHARMACY
800 NE OREGON STREET, SUITE 150
PORTLAND OR 97232
TELEPHONE: (971) 673-0001
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CONTROLLED SUBSTANCE

The Controlled Substance registration is not an independent registration, it must be issued in conjunction with a Correctional Facility Registration.

Please PRINT or TYPE

Business Name
Location Address
Phone Number ( ) - FAX # ( ) -
City, State, Zip
License & Renewal Mailing Address
Contact Person Title Contact Phone
City, State, Zip
Phone Number ( ) - FAX # ( ) -

Federal Tax ID # or Owner SSN: ___________________________ Does this outlet belong to a chain? [ ] Yes [ ] No

DRUG SCHEDULES (Check appropriate box(es))

[ ] Schedule I [ ] Schedule II [ ] Schedule III [ ] Schedule IV [ ] Schedule V

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

ALL APPLICANTS MUST ANSWER THE FOLLOWING:

1. Are you currently registered to manufacture, distribute or otherwise handle the controlled substances in the schedules for which you are applying under the laws of the Federal Government? [ ] YES [ ] NO

CURRENT FEDERAL REGISTRATION NUMBER ___________________________ 

2. Has the applicant 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. Has the applicant 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, ATTACH LETTER SETTING FORTH THE CIRCUMSTANCES.

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

MAIL THIS APPLICATION WITH REQUIRED DOCUMENTS, AND FEES, PAYABLE TO THE OREGON BOARD OF PHARMACY.

ALL RETURNED CHECKS WILL BE ASSESSED A $35.00 RETURNED CHECK FEE PURSUANT TO ORS 30.7015

Revised July 1, 2013