APPLICATION FOR REGISTRATION

DISPENSING PRACTITIONER 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

DISPENSING PRACTITIONER DRUG OUTLET (DPDO) FEE: $100.00 (WAIVED UNTIL 1/1/19)

Dear Applicant:

Enclosed is the Dispensing Practitioner Drug Outlet Registration Application. This application is for a practitioner’s facility that engages in dispensing certain FDA approved human prescription drug therapies greater than a 72 hours’ supply or any medication refill.

A practitioner’s facility is **exempt** from this registration requirement if the practitioner and facility only engage in:

- Dispensing FDA approved drug samples; **or**
- Dispensing Medication Assistance Program (MAP) drugs; **or**
- Dispensing homeopathic products; **or**
- Dispensing natural thyroid supplemental products; **or**
- Dispensing a small amount of drugs to start therapy or incidental to a procedure or office visit, up to a 72 hour supply; **or**
- An amount greater than a 72 hour supply if the drug is:
  - A drug in the manufacturer’s original unit-of-use packaging, such as a metered-dose inhaler or bottle of fluoride rinse; **or**
  - A full course of therapy, if in the professional judgment of the practitioner would be in the patient’s best interest, such as a course of antibiotic therapy.

For additional information and requirements, please see the DPDO rules at: [http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_855/855_043.html](http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_855/855_043.html) (OAR 855-043-0505-0560)

A description of the organization and dispensing process is required to complete the application. The description (Policies & Procedures) shall address all items including: drug acquisition, storage, security, labeling, and record keeping. This information must be submitted with your application for approval. (See page 2 of application)

Oregon law **requires** each facility to conduct an annual self-inspection by completing a self-inspection report by **February 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 DPDO is in compliance with state and federal laws and rules governing the drug outlet.

Dispensing Practitioner Drug Outlet registrations expire March 31 annually. Fees are not prorated.

Oregon Revised Statues & Administrative Rules are available for review on the web at: www.pharmacy.state.or.us.
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DISPENSING PRACTITIONER DRUG OUTLET FEE

PLEASE CHECK APPROPRIATE BOXES:

[ ] New Outlet  Start / Effective Date: ________________

[ ] License Reinstatement  [ ] Owner Change  [ ] Location Change  [ ] Name Change Only - No fee required
License Number: ________________ Date Effective: ________________

A change of ownership or location requires the submission of a new application and registration fee within 15 days.

Please PRINT or TYPE

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

Outlet Name: ________________________________

Owner / Corporate / LLC Name: ________________________________

Federal Tax ID # ________________________________

Location Address: ________________________________

City, State, Zip ________________________________

Phone Number: (______) - _______ FAX Number: (______) - __________

License & 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 ______________

What days/times in the work week is most suitable for a scheduled inspection?

Days of week: ________________________ Times of day: ________________________

Facility Contact Person: ________________________ Title ________________________ Contact Phone __________________

Facility Contact Person Email Address: ________________________________
Does this facility dispense controlled substances?  □ Yes  □ No

BE SURE THE POLICIES AND PROCEDURES ARE ATTACHED TO THIS APPLICATION ALONG WITH THE DESCRIPTION OF THE ORGANIZATION AND DISPENSING PROCESS.

Policies and procedures have been developed for the following: If no, please explain.

[ ] Yes [ ] No  Drug acquisition
[ ] Yes [ ] No  Drug security
[ ] Yes [ ] No  Drug storage
[ ] Yes [ ] No  Dispensing / Labeling of drugs
[ ] Yes [ ] No  Record keeping
[ ] Yes [ ] No  Disposal of unusable / Expired drugs
[ ] Yes [ ] No  Staff training

Please answer all of the following:

1. [ ] Yes [ ] No  Before purchasing a drug from any distributor, do you verify that the vendor is registered with the Board and legally authorized to sell the drug? You can access the license verification page at https://obop.oregon.gov/LicenseeLookup/

2. [ ] Yes [ ] No  Are all practitioners that will dispense drugs registered appropriately with their healthcare Board?

3. [ ] Yes [ ] No  Has disciplinary action ever been taken, or is any such action currently pending against any of the persons or the facility 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.

Dispensing Practitioner(s) Name(s) & License Number(s):

________________________________________________________________________  ______________________________________________________________________
________________________________________________________________________  ______________________________________________________________________
________________________________________________________________________  ______________________________________________________________________
________________________________________________________________________  ______________________________________________________________________

The undersigned hereby certifies that all the information contained in this application for registration is true and correct and that all the provisions of the law relative to the conduct of business operating there under will faithfully be observed. I also understand that under ORS 689.405(1) the furnishing of any false information is grounds for denial of registration.

Print or Name of Dispensing Practitioner __________________________________________ Signature of Dispensing Practitioner __________________________ Date ______________

MAIL THIS APPLICATION WITH REQUIRED DOCUMENTS AND FEES (WAIVED UNTIL 1/1/19), 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)
Ownership Information

Please check the appropriate box:

[ ] Corporation or LLC  [ ] Individual Owner, Trustee or Receiver  [ ] Partnership

Owner Name: __________________________________________________________

Parent Company Name (If entity is owned by another entity): ______________________

Complete the information below for officers, members or partners if owned by a corporation, limited liability company or partnership. This page may be duplicated as needed.

1. Name and Title: ______________________________________________________
   Address: ____________________________________________________________
   City, State, Zip: ______________________________________________________
   Phone Number: _______________________________________________________
   Email Address: _______________________________________________________

2. Name and Title: ______________________________________________________
   Address: ____________________________________________________________
   City, State, Zip: ______________________________________________________
   Phone Number: _______________________________________________________
   Email Address: _______________________________________________________

3. Name and Title: ______________________________________________________
   Address: ____________________________________________________________
   City, State, Zip: ______________________________________________________
   Phone Number: _______________________________________________________
   Email Address: _______________________________________________________

4. Name and Title: ______________________________________________________
   Address: ____________________________________________________________
   City, State, Zip: ______________________________________________________
   Phone Number: _______________________________________________________
   Email Address: _______________________________________________________