

Supplemental Information Form
Supervising Physician Dispensing 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.

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: _____

Phone / Fax Number: _____

Federal Tax ID Number: _____

Point of Contact Name: _____

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: (List name & address of President, Vice President and Secretary.)

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

Corporate Name: _____

President: _____

Vice President: _____

Member(s): _____

State in which Incorporated: _____

Address: _____

**Consultant Pharmacist
Contact Information**

NAME: _____

ADDRESS: _____

CITY, STATE ZIP: _____

PHONE NUMBER: _____

FAX: _____

EMAIL ADDRESS: _____

SIGNATURE OF CONSULTANT PHARMACIST

DATE

FIRST AND LAST NAME OF CONSULTANT PHARMACIST

CONSULTANT PHARMACIST EMAIL ADDRESS FOR BOARD USE

The Consultant Pharmacist signing this document acknowledges reading and understanding the Supervising Physician Dispensing Outlet Rules as defined in OAR Division 43 and the requirement to comply with Oregon's Laws and Rules.