APPLICATION FOR REGISTRATION
SUPERVISING PHYSICIAN DISPENSING 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

SUPERVISING PHYSICIAN DISPENSING DRUG OUTLET                                            FEE: $175.00
CONTROLLED SUBSTANCE REGISTRATION (If Applicable)                                       FEE: $ 50.00

Dear Applicant:

Enclosed is the Supervising Physician Dispensing Drug Outlet Registration Application. This application is for a physician or physician organization that supervises a physician assistant with dispensing authority. The Supervising Physician Dispensing Outlet Registration will allow a physician or physician organization that supervises a physician assistant with dispensing authority to dispense from the registered dispensing site. Listed below are the required supplemental items needed to complete your application.

1. 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 1 of application)

2. NEW, RELOCATED OR REMODELED SUPERVISING PHYSICIAN DISPENSING DRUG OUTLETS must submit an 8.5” x 11” floor plan, drawn to scale (can be hand drawn). Floor plans must identify the location of sinks, refrigerators, windows and doors. Additionally, you must note whether windows/doors are secured or unsecured.

3. Each Supervising Physician Dispensing Drug Outlet must obtain a consultant pharmacist and must have a supervising physician. If you should have a change in consultant pharmacist or supervising physician, the Board of Pharmacy must be notified within 15 days of the change.

4. OREGON CONTROLLED SUBSTANCE ACT APPLICATION. Be advised that the Controlled Substance Registration is not an independent registration. It must be issued in conjunction with a Supervising Physician Drug Outlet Registration. If your facility does not handle controlled substances, please check the box “Not Applicable” and return it with the Supervising Physician Drug Outlet Application. Note: The controlled substance fee is not required if the application is marked “Not Applicable.” Supervising Physician Drug Outlet Applications will not be processed without the completion of the Controlled Substance Application

5. OREGON REVISED STATUTES & ADMINISTRATIVE RULES are available for review on our web site at: www.pharmacy.state.or.us. If electronic copies of laws and rules are accessible to all staff members, a hard copy is not required.

Please be aware that your application will be scheduled for review once all required paperwork and fee(s) are received. Your registration is to be in your possession PRIOR to doing business in Oregon. Supervising Physician Dispensing Drug Outlets expire March 31 annually and fees are not prorated. Renewals are due and must be post-marked by February 28 annually, which is one (1) month prior to the expiration date of your license. Renewal notices will be mailed out in mid-January.
APPLICATION FOR REGISTRATION

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(Expires March 31 Annually)

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SUPERVISING PHYSICIAN DISPENSING DRUG OUTLET     FEE $175.00

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

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 ______

Consultant Pharmacist Name: ___________________________ License No. ___________________________

Contact Person: ___________________________ Title: ___________________________ Contact Phone: __________

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  Receiving drugs ___________________________

[ ] Yes [ ] No  Security ___________________________

[ ] Yes [ ] No  Drug storage ___________________________

[ ] Yes [ ] No  Dispensing of drugs ___________________________

[ ] Yes [ ] No  Record keeping ___________________________

[ ] Yes [ ] No  Disposal of unusable drugs ___________________________

[ ] Yes [ ] No  Staff training ___________________________
Supervising Physician

Name

License No.

Address

City, State, Zip

Phone Number

Fax

Email Address

Normal Business Hours of Facility

Please answer all of the following:

1. [ ] 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.

2. [ ] Yes [ ] No Before purchasing a drug from any distributor, do you verify that the vendor is legally authorized to sell the drug?

3. [ ] Yes [ ] No Physician assistants that will dispense drugs will be registered appropriately with the Oregon Medical Board? Note: This includes Dispensing Privileges granted by the Oregon Medical Board per Oregon Administrative Rule.

Dispensing Physician Assistant(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 Supervising Physician          Signature of Supervising Physician          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)
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: ___________________________________________________________
   SSN/Federal Tax ID: _______________________________________________________
   Address: ________________________________________________________________
   City, State, Zip: __________________________________________________________
   Phone Number: __________________________________________________________
   Email Address: __________________________________________________________

2. Name and Title: ___________________________________________________________
   SSN/Federal Tax ID: _______________________________________________________
   Address: ________________________________________________________________
   City, State, Zip: __________________________________________________________
   Phone Number: __________________________________________________________
   Email Address: __________________________________________________________

3. Name and Title: ___________________________________________________________
   SSN/Federal Tax ID: _______________________________________________________
   Address: ________________________________________________________________
   City, State, Zip: __________________________________________________________
   Phone Number: __________________________________________________________
   Email Address: __________________________________________________________
CONTROLLED SUBSTANCE
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
www.pharmacy.state.or.us

FEE $ 50.00
ALL FEES ARE NON REFUNDABLE
(If Not Applicable, please check here) [ ]
WARNING: ORS 475.135 (1) (e) The furnishing of false information is grounds to deny registration.

Please PRINT or TYPE
Outlet 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: ________________________________

DRUG SCHEDULES (Check appropriate box(es):
[ ] Schedule I [ ] Schedule II [ ] Schedule III [ ] Schedule III [ ] Schedule IV [ ] Schedule V
Attach list of stocked Schedule I Drugs [ ] Narcotic [ ] Non-Narcotic

ALL APPLICANTS MUST ANSWER THE FOLLOWING:
1. Is the facility listed above 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. 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

3. Has the applicant ever surrendered a previous Federal Controlled Substances Registration (FCSA) or had a FCSA Registration revoked, suspended or denied? [ YES [ NO

4. 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 4, ATTACH LETTER SETTING FORTH THE CIRCUMSTANCES.

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

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OREGON BOARD OF PHARMACY
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TELEPHONE: (971)673-0001
www.pharmacy.state.or.us

OREGON PHARMACY LAWS AND ADMINISTRATIVE RULES
FEE $25.00

Please Mail to:

NAME ____________________________________________

EMAIL: ____________________________________________

FACILITY NAME ____________________________________

ADDRESS __________________________________________

CITY, STATE & ZIP CODE ______________________________

Number of sets requested _______ Amount enclosed $___________ ($25.00 per set)

Set(s) ordered for:

Pharmacist [ ] Intern [ ] Reciprocal [ ] Pharmacy [ ] Other [ ]

Make checks payable to: Oregon Board of Pharmacy
800 NE Oregon St, Ste 150
Portland, OR 97232

Please Note:

• Administrative Rules are updated through the Secretary of State’s Office within 30 days of being filed.

• Electronic versions of pharmaceutical references required under Oregon Administrative Rule 855-041-1035 satisfy the minimum equipment requirement for a pharmacy.

• The Oregon Board of Pharmacy Official Newsletter is available online. This will provide direct access to the e-Newsletter for Oregon licensed pharmacy technicians, pharmacy interns and pharmacists, as well as any other persons interested in Board of Pharmacy news. Click this link to sign up to receive the Newsletter: http://www.oregon.gov/pharmacy/Pages/Newsletters.aspx. You can also sign up for Board Meeting Agendas, Rulemaking Notices and rule adoption information

• The Laws and Rules for the Oregon Board of Pharmacy may be found on the Boards website at http://www.pharmacy.state.or.us. Included are:

  o Oregon Revised Statute Chapter 689, Oregon Pharmacy Act
  o Oregon Revised Statute Chapter 475, Uniform Controlled Substance Act
  o Oregon Administrative Rules Chapter 855

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