



## **Pharmaceutical Manufacturer License Application Packet**

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### **In order to process your request:**

**Mail your application with initial documentation and your check or money order payable to:**

Department of Health  
PO Box 1099  
Olympia, WA 98507-1099

**Send other documents not sent with initial application to:**

Pharmacy Board Credentialing  
PO Box 47877  
Olympia, WA 98504-7877

**Contact us:**

360.236.4700

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## Application Instructions Checklist

When your application for pharmaceutical manufacturer license is received by the Department of Health, you will be notified of any outstanding documentation needed to complete the process.

**Note: If you are applying for a Control Substance Act registration in addition to your manufacturer license, be sure to send the additional nonrefundable fee.**

**All non-resident and out-of-state applicants must provide a copy of the resident license and last inspection.**

Indicate type of application—new, change of ownership, change of location, or name change.

- **New**—First time requesting a manufacturer license.
- **Change of Ownership**—When name of legal owner/operator changes resulting from the sale of licensed agency.
- **Change of Location**—Changing the location address of manufacturer. Be sure to include you current license number.
- **Name change only**—Changing the name of your manufacturer. Be sure to list your current facility name.

**Check One:**

Please check your legal owner/operator business structure type according to your Washington State Master Business License.

**Application Fee:** you can check the [fee page](#) for current fees.

**1. Demographic Information:**

**Uniform Business Identifier Number (UBI #):** Enter your Washington State UBI #. All Washington State businesses must have UBI #s. City, county, and state government documents also have UBI #'s.

**Federal ID Number (FEIN #):** Enter your Federal ID Number, if the business has been issued one.

**Legal Owner/Operator Name:** Enter the owner's name as it appears on the UBI/ Master Business License.

**Mailing Address:** Enter the owner's complete mailing address.

**Phone and Fax Numbers:** Enter the owner's phone and fax numbers.

**Email and Web Address:** Enter your email address, if you have one.

**Facility/Agency Name:** Enter the agency's name as advertised on signs, brochures or Web site.

**Physical Address:** Enter the agency's physical street location including city, state, zip code, and county.

**Phone and Fax Numbers:** Enter the agency's phone and fax number.

**Mailing Address:** Enter the agency's mailing address, if different than physical address.

**2. Facility Specific Information:**

**Type of Manufacturer:** Check all types of manufacturers that apply.

**Drug Enforcement Administration (DEA) Number:** Enter your DEA Registration Number.

**Background Questions:** Check yes or no and if you check yes, list and explain on a separate sheet of paper.

**3. Contact Information:**

Enter name, title, phone number, fax number, and email address.

**4. Additional Information:**

**Corporation Information:** Enter date of incorporation, corporate number, and state of corporation.

**Legal Owner:** List the names, titles, addresses, and phone numbers of the corporate officers, partners, members, managers, etc. Attach additional sheet of paper as needed.

**Change of Ownership Information:** List the previous legal owner name, previous name of facility, previous license number, effective date of ownership change and physical address, if applicable.

**Signature:**

Signature of legal owner or authorized representative.

Date signed.

Print name of legal owner or authorized representative.

Print title of legal owner or authorized representative.

Date  
Stamp  
Here

Revenue 0262010000

## Pharmaceutical Manufacturer License Application

This is for:

- New   
  Change of Ownership   
  Change of Location—Current License # \_\_\_\_\_  
 Name Change Only—Current Facility Name \_\_\_\_\_

**Check One**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Association                   | <input type="checkbox"/> Limited Partnership    | <input type="checkbox"/> Sole Proprietor          |
| <input type="checkbox"/> Corporation                   | <input type="checkbox"/> Municipality (City)    | <input type="checkbox"/> State Government Agency  |
| <input type="checkbox"/> Federal Government Agency     | <input type="checkbox"/> Municipality (County)  | <input type="checkbox"/> Tribal Government Agency |
| <input type="checkbox"/> Limited Liability Company     | <input type="checkbox"/> Non-Profit Corporation | <input type="checkbox"/> Trust                    |
| <input type="checkbox"/> Limited Liability Partnership | <input type="checkbox"/> Partnership            |   |

**1. Demographic Information**

UBI #		Federal Tax ID (FEIN) #	
Legal Owner/Operator Name			
Mailing Address			
City	State	Zip	County
Phone (enter 10 digit #)		Fax (enter 10 digit #)	
Email Address		Web Address:	
Facility/Agency Name (Business name as advertised on signs or Web site)			
Physical Address			
City	State	Zip	County
Facility Phone (enter 10 digit #)		Fax (enter 10 digit #)	
Mailing Address (If different than physical address)			
City	State	Zip	County

## 2. Facility Specific Information

### Type of Manufacturer (Check all that apply):

- Controlled Substance Manufacturer (provide DEA#) \_\_\_\_\_
- Non-controlled Substance Manufacturer
- Repackager

Drug Enforcement Administration (DEA) Registration Number \_\_\_\_\_

### Background Questions

1. Have any applicants, partners, or managers had a suspension, revocation, or restriction of a professional license? .....    
If yes,, list and explain on a separate sheet of paper.
2. Have any applicants, partners, or managers been found guilty of a drug or controlled substance violation? .....    
If yes, list and explain on a separate sheet of paper.
3. Has any owner or officer ever been found guilty of a drug, controlled substance, or moral turpitude violation? .....    
If yes, attach an explanation in detail, providing the circumstances, places, dates, and outcomes.

## 3. Contact Information

Responsible Person for Facility

Phone (Enter 10 digit #)

Title of Responsible Person for Facility

Email Address

Contact Person for Regulatory Issues

Phone (Enter 10 digit #)

Title of Contact Person for Regulatory Issues

Email Address

#### 4. Additional Information

Date of Incorporation

Corporate Number

State of Corporation

#### Legal Owner Information—attach additional sheets as needed

List names, addresses, phone numbers, and titles of corporate officers, partners, members, managers, etc.

Name	Address	Phone (Enter 10 digit #)	Title

#### Change of Ownership Information

Previous Name of Legal Owner

Previous Name of Facility

Previous Pharmacy License #

Effective Date of Ownership Change

Physical Address

### Signature

I certify that I have receive, read, understood, and agree to comply with state law and rule regulating this licensing category. I also certify that the information herein submitted is true to the best of my knowledge and belief.

\_\_\_\_\_  
Signature of Owner/Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Title

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## **RCW/WAC and Online Web Site Links**

### **RCW/WAC Links**

Uniform Disciplinary Act.....	<a href="#"><u>UDA RCW 18.130</u></a>
Administrative Procedure Act .....	<a href="#"><u>APA RCW 34.05</u></a>
Administrative procedures and requirements.....	<a href="#"><u>WAC 246-12</u></a>
Pharmacy RCW.....	<a href="#"><u>RCW 18.64</u></a>
Athletic Trainer, WAC .....	<a href="#"><u>WAC 246-863</u></a>

### **OnLine**

AIDS Training Resources .....	<a href="#"><u>Reference Page</u></a>
Pharmacy Board .....	<a href="#"><u>Web Page</u></a>

### **Required Hours of Training**

Pharmacist.....	7 hours
Technician.....	4 hours
Assistant.....	4 hours