



Revenue Section
PO Box 1099
Olympia WA 98507-1099
360.236.4700
<https://fortress.wa.gov/doh/hpqa1/hps4/Pharmacy/default.htm>

Poison Distributor License Application Packet

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Important Information:

Return completed application and check or money order payable to:

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

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Revenue Section

PO Box 1099

Olympia WA 98507-1099

360.236.4700

<https://fortress.wa.gov/doh/hpqa1/>

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Poison Distributor License Application Checklist and Instructions

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

New – First time requesting a pharmacy license. Consult fee schedule for fee amount required.

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 pharmacy. Be sure to include your current license number.

Name Change Only – Changing the name of your pharmacy. 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.

Section #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 departments 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 number.

Email and Web Address: Enter the owner's email and agency Web addresses, if applicable.

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 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.

Poison Distributor License Application Checklist and Instructions (continued)

Section #2: Facility Specific Information:

Type of Poison: Check all that apply.

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

Section #3: Key Individuals:

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

Section #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, member, managers, etc. Attach additional sheet, if necessary.

Change of Ownership Information: If applicable, list the previous legal owner name, previous name of facility, previous license #, effective date of ownership change and physical address.

List of Pharmacists: List all pharmacists working in your pharmacy. Attach additional sheets if needed.

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.



Washington State Department of

Health

Revenue Section

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Date Stamp Here

Fee
<input type="checkbox"/> Poison Distributor
<i>All application fees are nonrefundable</i>

Revenue: 0262010000

Poison Distributor License Application

This is for: New Change of Ownership Change of Location – Current License # _____
 Name Change Only (\$15.00 duplicate fee.) – 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# ()		Fax# ()	
Email Address		Web Address:	
Facility/Agency Name (Business name as advertised on signs or Web site)			
Physical Address			
City	State	Zip	County
Facility Phone# ()		Fax# ()	
Mailing Address (If different than physical address)			
City	State	Zip	County

2. Facility Specific Information

Type of Poison (Check all that apply)

Arsenic Strychnine Cyanide Other (please specify) _____

Background Questions

YES NO

1. Have any applicants, partners, or managers had a suspension, revocation, or restriction of a professional license? YES NO
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? YES NO
If yes, list and explain on a separate sheet of paper.

3. Key Individuals

Contact Person

Telephone Number

Email Address

Name

Title

()

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 #

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 received, 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