

## **Drug Dog Handlers Registration Application Packet**

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### **Important Information:**

#### **Mail application and check or money order to:**

Department of Health  
Revenue Section  
P.O. Box 1099  
Olympia, WA 98504-1099



Revenue Section  
P.O. Box 1099  
Olympia WA 98507-1099  
360.236.4700

## **Drug Dog Handlers Registration Application Checklist & Instructions**

**Fees:** Check all that apply; pharmacy location, controlled substance act, ancillary utilization (complete additional application), or differential hours (complete additional application).

**NOTE:** If you are applying for ancillary utilization you have to complete an ancillary plan and send it in with your application.

**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.

**Section #2: Facility Specific Information:**

**Type of Pharmacy:** Please check which type of pharmacy you are applying for; community retail, hospital, jail, long-term care, mail-order, nuclear, parenteral, or internet (include web address).

**Hours Pharmacy will be open:** Enter hours pharmacy will be open for Monday-Friday, Saturday, Sunday, and any holiday hours you'll be open.

**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: Supervision:**

Enter name of pharmacist in charge, license number, and date of appointment.

**Section #5: 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.

Date  
Stamp  
Here

Fees
<input type="checkbox"/> Drug Dog Handlers Registration Fee <i>All application fees are nonrefundable</i>

Revenue: 0262010000

## Drug Dog Handlers Registration

This is for:  New     Change of Ownership     Change of Location – Current License # \_\_\_\_\_  
 **Name Change Only (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

**Drug Enforcement Administration (DEA) Information**

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

**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 Name	Title	Telephone Number ( )	Email Address
Contact Person Name	Title	Telephone Number ( )	Email Address

**4. Primary Registration**

Name	Registration Date	Date of Appointment
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**5. Additional Information**

Date of Incorporation	Corporate Number	State of Corporation
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**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

**List all Pharmacist Attach Additional Sheets if Needed**

Name	Title	License#

**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