

Drug Other Controlled Substance Registration 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
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700



Revenue Section
P.O. Box 47877
Olympia WA 98504-7877
360.236.4700

Drug Other Controlled Substance Registration Application Checklist and Instructions

All application fees are non-refundable: Fees are located on the Board of Pharmacy [fee page](#).

Indicate type of application – new, change of ownership, change of location, or change in primary registrant.

New – First time requesting a controlled substance registration. 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. Be sure to include your current license number.

Name Change Only – Changing the name of your organization. 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/Federal ID Number.

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:

Check Facility Type:

- Analytical labs.
- Methadone treatment facility.
- School laboratories.

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

Drug Enforcement Administration (DEA) Number : Enter your DEA number

Section #3: Key Individuals:

Enter name, title, telephone number, and email address.

Section #4: Primary Registrant Information:

Enter name, telephone number, registration date, 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.

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

P.O. Box 1099

Olympia WA 98507-1099

360.236.4700

Date Stamp Here

Fees (check all that apply)

Drug Other Controlled Registration

Precursor Chemical

Check the [fee page](#) for current fees.

All application fees are nonrefundable

Revenue: 0262010000

Drug Other Controlled Substance Registration Application

This is for: New Change of Ownership Change of Location Name Change Only (Reissue Fee) Current Facility Name Current License# _____

Check One

- Association Corporation Federal Government Agency Limited Liability Company Limited Liability Partnership Limited Partnership Municipality (City) Municipality (County) Non-Profit Corporation Partnership Sole Proprietor State Government Agency Tribal Government Agency Trust

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 Website)

Physical Address

City State Zip County

Facility Phone# () Fax# ()

Mailing Address (If different than physical address)

City State Zip County

2. Facility Specific Information

Check One:

Analytical Labs Methadone Treatment Facility School Laboratories

Background Questions

Yes No

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.

Drug Enforcement Administration (DEA) Number

Enter DEA # _____

3. Key Individuals

Contact Person

Name _____ Title _____
Telephone # _____ Email Address _____

4. Primary Registration

Name _____ Telephone # _____
Registration Date _____ Date of Appointment _____

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
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Physical Address

Signature

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

Signature of Owner/Authorized Representative of Pharmacy

Date

Print Name

Print Title