



Washington State Department of  
**Health**  
Pharmacy Commission  
P.O. Box 47877  
Olympia WA 98507-7877  
360-236-4700

## Hospital Pharmacy Associated Clinics Instructions Checklist

When your addendum for a hospital pharmacy associated clinic is received by the Department of Health, you will be notified of any outstanding documentation needed to complete the process.

### Indicate type of application

- **New Clinic**—The clinic(s) you are adding to your hospital pharmacy license have not been previously associated with your license.
- **Update to Current Clinic**—You are making an update or change to a clinic(s) that you currently have listed as associated with your hospital pharmacy.

Note: If you are removing a clinic(s) from your hospital pharmacy, this form is not required. Please refer to [WAC 246-873A-095](#) to remove an associated clinic.

**Application Fees:** Fees are non-refundable. You can check the online [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 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.

**Email and Web Address:** Enter the owner's email and agency Web addresses, if they have them.

**Pharmacy License #:** Enter the license number of the parent hospital pharmacy.

**Pharmacy Name:** Enter the pharmacy's name as advertised on signs, brochures or Web sites.

**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.

**2. Hospital Pharmacy Associated Clinics (HPAC) Locations:**

Complete this section for each clinic location you are adding under the hospital pharmacy license.

**3. 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.

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Date  
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Revenue: 0262010000

**Hospital Pharmacy Associated Clinics Form**

Complete this form if you are adding a new clinic or updating existing clinic information under your pharmacy hospital license. This form must be complete by the Hospital Pharmacy.

**Select One:**    New Clinic    Update to current clinic

**1. Demographic Information**

UBI #	Federal Tax ID (FEIN) #		
Legal Owner/Operator Name			
Pharmacy License #			
Hospital Pharmacy Name			
Physical Address			
City	State	Zip Code	County
Facility Phone (enter 10 digit #)		Fax (enter 10 digit #)	

**2. Hospital Pharmacy Associated Clinics (HPAC) Locations**

Clinic Name	Clinic Phone #		
Site Address			
City	State	Zip Code	County
Does this clinic possess controlled substance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list your DEA #.		DEA #	
<p>Check which service your HPAC provides:</p> <p><input type="checkbox"/> <b>Category 1</b>—The HPAC receives drugs transferred from the parent hospital pharmacy and does not perform sterile or non-sterile compounding of drugs.</p> <p><input type="checkbox"/> <b>Category 2</b>—The HPAC received drugs transferred from the parent hospital pharmacy and performs sterile or non-sterile compounding of drugs.</p>			

Clinic Name			Clinic Phone #
Site Address			
City	State	Zip Code	County
Does this clinic possess controlled substance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list your DEA #.		DEA #	
Check which service your HPAC provides:			
<input type="checkbox"/> <b>Category 1</b> —The HPAC receives drugs transferred from the parent hospital pharmacy and does not perform sterile or non-sterile compounding of drugs.			
<input type="checkbox"/> <b>Category 2</b> —The HPAC received drugs transferred from the parent hospital pharmacy and performs sterile or non-sterile compounding of drugs.			
Clinic Name			Clinic Phone #
Site Address			
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<input type="checkbox"/> <b>Category 1</b> —The HPAC receives drugs transferred from the parent hospital pharmacy and does not perform sterile or non-sterile compounding of drugs.			
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Clinic Name			Clinic Phone #
Site Address			
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Does this clinic possess controlled substance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list your DEA #.		DEA #	
Check which service your HPAC provides:			
<input type="checkbox"/> <b>Category 1</b> —The HPAC receives drugs transferred from the parent hospital pharmacy and does not perform sterile or non-sterile compounding of drugs.			
<input type="checkbox"/> <b>Category 2</b> —The HPAC received drugs transferred from the parent hospital pharmacy and performs sterile or non-sterile compounding of drugs.			

### 3. 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