Revenue Section
PO Box 1099
Olympia WA 98507-1099
360.236.4843
https://fortress.wa.gov/doh/hpqa1/hps4/Pharmacy/default.htm

Pharmacy License Application Packet

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Important Information:

Mail this information to:

Department of Health
Revenue Section
PO Box 1099
Olympia, WA 98504-1099

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Pharmacy License Application Checklist and 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

☐ **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.

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Date Stamp Here

Fees (Check all that apply)
☐ Pharmacy Location
☐ Controlled Substance Act
☐ Ancillary Utilization (Complete additional application)
☐ Differential Hours (Complete additional application)
All application fees are nonrefundable

Revenue: 0262010000

Pharmacy 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

☐ Association	☐ Limited Partnership	☐ Sole Proprietor
☐ Corporation	☐ Municipality (City)	☐ State Government Agency
☐ Federal Government Agency	☐ Municipality (County)	☐ Tribal Government Agency
☐ Limited Liability Company	☐ Non-Profit Corporation	☐ Trust
☐ Limited Liability Partnership	☐ 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 Pharmacy (Check all that apply)

☐ Community/Retail ☐ Hospital ☐ Jail ☐ Long-term Care (LTC)

☐ Mail–Order ☐ Nuclear ☐ Parenteral ☐ Internet

Indicate the hours the Pharmacy will be open

Monday—Friday	Saturday	Sunday	Holidays

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.

3. Key Individuals

Contact Person Name Title	Telephone Number ( )	Email Address

4. Supervision

Pharmacist in Charge	License Number	Date of Appointment

5. 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

List all Pharmacist–attach additional sheets if needed

Name	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 of Pharmacy

Date

Print Name

Print Title