Washington State Department of Health

Drug Other Controlled Substance Registration Application Packet

Contents:

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Pharmacy Quality Assurance
Commission Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

(This page intentionally left blank.)

Drug Other Controlled Substance Registration Application Checklist and Instructions

☐ Indicate type of application—New, change of ownership, change of location, or name change.

- **New**—First time requesting a controlled substance registration.
- **Change of Ownership**—When name of legal owner/operator changes resulting from the sale of licensed agency.
- **Change of Location**— Change 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.
- **Mobile OTP -** Indicate mobile opioid treatment program unit.

☐ **Check One:**
Please check your legal owner/operator business structure type according to your Washington State Master Business License.

☐ **Application Fees:** Check one; with controlled substance or without controlled substance. 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.

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 they have them.

Facility/Agency Name: Enter the agency'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.

Mailing Address: Enter the agency's mailing address, if different than physical address.

Email Address: Enter the agency's email address, if available.

☐ **2. Facility Specific Information:**
Check Facility Type:

- Analytical labs
- Methadone treatment facility
- School laboratories
- Behavioral Health agency

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

☐ **3. Key Individuals:**
Enter name, title, telephone number, and email address.

☐ **4. Primary Registrant Information:**
Enter name, telephone number, registration date, and date of appointment.

☐ **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

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 ☐ Mobile OTP - Credential Number _____

☐ Change of Location - Current Credential Number _____

☐ **Name Change Only (Reissue 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		Mobile OTP Unit VIN and License Plate (Only if box checked)	
Mailing Address			
City	State	Zip Code	County
Phone (enter 10 digit #)		Fax (enter 10 digit #)	
Email Address		Web Address	

Facility/Agency Name (Business name as advertised on signs or Website)			
Physical Address			
City	State	Zip Code	County
Facility Phone (enter 10 digit #)		Fax (enter 10 digit #)	
Mailing Address (If different than physical address)			
City	State	Zip Code	County

2. Facility Specific Information

Check One:

☐ Analytical Labs ☐ Methadone Treatment Facility ☐ School Laboratories ☐ BHA

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 Drug Enforcement Administration (DEA) #_____

3. Key Individuals

Contact Person Name _____ Title _____

Phone (enter 10 digit #) _____ Email Address _____

4. Primary Registrant

Name _____ Phone (enter 10 digit #) _____

Registration Date _____ 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 number	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 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

RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Pharmacy Laws, RCW 18.64

Pharmacy Rules, WAC 246-945

On-Line

Pharmacy Quality Assurance Commission, Web Page