Pharmaceutical Wholesaler License 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
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
Application Instructions Checklist

When your application for pharmaceutical wholesaler license is received by the Department of Health, you will be notified of any outstanding documentation needed to complete the process.

Note: If you are applying for a Controlled Substance Act (CSA) registration in addition to your wholesaler license be sure to send the additional nonrefundable fee.

All non-resident and out-of-state applicants must provide a copy of the resident license and last inspection.

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

- **New**—First time requesting a pharmacy wholesale license.
- **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 wholesaler. Be sure to include your current license number.
- **Name Change Only**—Changing the name of your wholesaler. 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.

☐ Application Fee: You can check the 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 FEIN #, 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.

2. Facility Specific Information:

Type of wholesaler: Check all types of wholesalers that apply.

This wholesaler will ship to: Check all places you will be shipping to.

Type of products wholesaler will handle: Check all type of products you will be handling.

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

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

3. Contact Information:

Enter name, title, phone number, fax number, and email address.

4. Additional Information:

Corporation information: Enter date of incorporation, corporate number, and state of corporation.

Other states you are licensed: List any other states you have been or are licensed.

Legal Owner: List the names, titles, addresses, and phone numbers of the corporate officers, partners, member, managers, etc. Attach another sheet of paper as needed.

Change of Ownership Information: List the previous legal owner name, previous name of facility, previous license number, effective date of ownership change and physical address, if applicable.

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.
Pharmaceutical Wholesaler License Application

This is for:  
☐ New  ☐ Change of Ownership  ☐ Change of Location—Current License #______________
☐ Name Change Only  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

<table>
<thead>
<tr>
<th>UBI #</th>
<th>Federal Tax ID (FEIN) #</th>
</tr>
</thead>
</table>

Legal Owner/Operator Name

Mailing Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

Phone (enter 10 digit #)  Fax (enter 10 digit #)

Email Address

Web Address:

Facility/Agency Name (Business name as advertised on signs or Web site)

Physical Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

Facility Phone (enter 10 digit #)  Fax (enter 10 digit #)

Mailing Address (If different than physical address)

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>
### 2. Facility Specific Information

**Type of wholesaler** (Check all that apply):

- [ ] Distribution Center for Multiunit (Chain)
- [ ] Hospital Corporation Distribution Center
- [ ] Reverse Distributor
- [ ] Wholesaler

**This wholesaler will ship to** (Check all that apply):

- [ ] Community Pharmacies
- [ ] Hospital Pharmacies
- [ ] Retail Outlets (Shopkeepers)
- [ ] Veterinarians
- [ ] Hospitals
- [ ] Physicians or Other Practitioners
- [ ] Wholesalers
- [ ] Other (describe)_________________________

**Type of products this wholesaler will handle** (Check all that apply):

- [ ] List 1 Chemicals
- [ ] Legend (Prescription Drugs)
- [ ] Controlled Substances—Schedule(s) _________________
- [ ] Veterinary Drugs
- [ ] Blood Products
- [ ] Over-the-counter Medications
- [ ] Medical Devices
- [ ] Other (describe)___________________________________________

Drug Enforcement Administration (DEA) Registration Number ______________________________________

**Check One:**

- [ ] In State
- [ ] Out of State

If out of state, date of last inspection ________________________________

**Background Questions**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>1. Have any applicants, partners, or managers had a suspension, revocation, or restriction of a professional license?</td>
<td></td>
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<tr>
<td>If yes, list and explain on a separate sheet of paper.</td>
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<tr>
<td>2. Have any applicants, partners, or managers been found guilty of a drug or controlled substance violation?</td>
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<td>If yes, list and explain on a separate sheet of paper.</td>
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<tr>
<td>3. Has any owner or officer ever been found guilty of a drug, controlled substance, or moral turpitude violation?</td>
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<tr>
<td>If yes, attach an explanation in detail, providing the circumstances, places, dates, and outcomes.</td>
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</tbody>
</table>

### 3. Contact Information

<table>
<thead>
<tr>
<th>Name of Responsible Person for Facility</th>
<th>Phone (enter 10 digit #)</th>
<th>Email Address</th>
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<tbody>
<tr>
<td>Title of Responsible Person for Facility</td>
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</table>

<table>
<thead>
<tr>
<th>Contact Person for Regulatory Issues</th>
<th>Phone (enter 10 digit #)</th>
<th>Email Address</th>
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<tbody>
<tr>
<td>Title of Contact Person for Regulatory Issues</td>
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</table>
### 4. Additional Information

<table>
<thead>
<tr>
<th>Date of Incorporation</th>
<th>Corporate Number</th>
<th>State of Corporation</th>
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</table>

Other states you are licensed in:

#### Legal Owner Information—attach additional sheets as needed

List names, addresses, phone numbers, and titles of corporate officers, partners, members, managers, etc.

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone (enter 10 digit #)</th>
<th>Title</th>
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#### Change of Ownership Information

<table>
<thead>
<tr>
<th>Previous Name of Legal Owner</th>
<th>Previous Name of Facility</th>
<th>Previous Pharmacy License #</th>
<th>Effective Date of Ownership Change</th>
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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       Date

______________________________       ________________________
Print Name       Print Title
(This page intentionally left blank.)
RCW/WAC and Online Website Links

RCW/WAC Links
Uniform Disciplinary Act, RCW 18.130
Uniform Controlled Substance Act, RCW 69.50
Administrative procedures and requirements, WAC 246-12
Standards of Professional Conduct, WAC 246-16
Pharmacy Practice Act, RCW 18.64
Pharmacy Wholesaler Rules, WAC 246-879

Online
AIDS Training Resources, Reference Page
Pharmacy Quality Assurance Commission, Web Page