Pharmacy Health Care Entity 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 pharmacy health care entity license is received by the Department of Health, you will be notified in writing of any outstanding documentation needed to complete the application process.

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

- **New**—First time requesting a pharmacy health care entity license.
- **Change of Ownership**—When name of legal owner/operator changes resulting from the sale of licensed health care entity.
- **Change of Location**—Include your current license number.
- **Name Change Only**—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 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 Information:

Drug Enforcement Administration Registration Number: Enter the federal DEA registration number if dispensing controlled substances. Enter “pending” if the Health Care Entity has not been issued its DEA registration number.

Pharmacist Consultant: Enter name of pharmacist, license number, and date of appointment.

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.

Legal Owner: List the names, titles, addresses, and phone numbers of the corporate officers, partners, members, and managers. Attach additional completed pages if you need more space.

Change of Ownership Information: List the previous legal owner name, previous name of facility, previous health care entity license number, and effective date of ownership change.

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.
Pharmacy Health Care Entity License Application

This is for: □ New  □ Change of Ownership  □ Change of Location—Current License #__________

□ Name Change Only—Current Facility Name

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 Code  County

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

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

Physical Address

City  State  Zip Code  County

Facility Phone (enter 10 digit #)  Fax (enter 10 digit #)  Email Address:

Mailing Address (If different than physical address)

City  State  Zip Code  County
2. Facility Information

Drug Enforcement Administration (DEA) # ____________________________

<table>
<thead>
<tr>
<th>Background Questions</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have any applicants, partners, or managers had a suspension, revocation, denial, or restriction of a professional license?</td>
<td>☐</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 (including samples)?</td>
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<tr>
<td>If yes, list and explain on a separate sheet of paper.</td>
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<table>
<thead>
<tr>
<th>Pharmacist Consultant</th>
<th>License Number</th>
<th>Date of Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
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</table>

3. Contact Information

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

Legal Owner Information—attach additional completed pages if you need more space.
List names, addresses, phone numbers, and titles of corporate officers, partners, members, and managers.

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

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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</table>

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 | Date
---|---

Print Name | Print Title
RCW/WAC and Online Web Site 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 246-879*

**On-Line**

*AIDS Training Resources, Reference Page*

*Pharmacy Quality Assurance Commission, Web Page*