

Drug Other Controlled Substance Registration 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

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

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Drug Other Controlled Substance Registration Application Checklist and Instructions

- ☐ Indicate type of application—New, change of ownership, change of location, name change, or adding an OTP mobile unit.
- **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.
 - **Adding OTP Mobile Unit** - Adding an OTP mobile unit to an existing BHA credential.
- ☐ **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
- OTP Mobile Unit
- Fixed-Site Medication Unit

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.

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 ☐ Adding OTP Mobile Unit

☐ Change of Location - Current Credential Number _____

☐ **Name Change Only (Reissue [Fee](#))-** Current Facility Name _____

Check One

- | | | |
|--|---|---|
| <input type="checkbox"/> Association | <input type="checkbox"/> Limited Partnership | <input type="checkbox"/> Sole Proprietor |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Municipality (City) | <input type="checkbox"/> State Government Agency |
| <input type="checkbox"/> Federal Government Agency | <input type="checkbox"/> Municipality (County) | <input type="checkbox"/> Tribal Government Agency |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Non-Profit Corporation | <input type="checkbox"/> Trust |
| <input type="checkbox"/> Limited Liability Partnership | <input type="checkbox"/> 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

☐ OTP Mobile Unit - BHA Credential Number _____

☐ Fixed-Site Medication Unit - BHA Credential Number _____

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](#)

Online

[Pharmacy Quality Assurance Commission, Web Page](#)