

Drug Sample Distributor Registration Application Packet (Legend Drug)

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In order to process your request:

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

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent or with initial application to:

Pharmacy Quality Assurance
Commission Credentialing
PO 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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Application Instructions Checklist

When your application for drug sample distribution registration (legend drug) 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 drug sample distribution registration (legend drug) license.
- **Change of Ownership**—When name of legal owner/operator changes resulting from the sale of licensed drug sample distribution registration (legend drug).
- **Change of Location**—Changing your location address. 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:**

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 you 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.

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

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

☐ **2. Facility Information:**

Check one: Check whether in-state or out-of-state.

- If in state, you must complete legend drug sample distributors report located on the last page of the application.
- If out of state, provide copy of last inspection and copy of last inspection report.

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

Drug Enforcement Administration (DEA) Registration Number: Enter DEA registration number, if applicable.

☐ **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 license number, effective date of ownership change, and physical address.

24 hr phone number: List a day and night phone number. If a twenty-four hour telephone number is not available, complete the attached Legend Drug Sample Distributors Report form to provide the addresses of sites in this state at which the storage or distribution of the drug samples. The list of the sites and individuals must be update annually with the department.

Individual Representatives: Answer yes or no if individual representatives distribute controlled substance samples.

DEA Reporting Frequency: Indicate whether you report to the DEA Quarterly, Monthly, or Other. Indicate the frequency if you mark other. Indicate your next reporting due date.

☐ **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 Sample Distributor Registration without controlled substance
- ☐ Drug Sample Distributor Registration with controlled substance

All application fees are nonrefundable. You can check the online [fee page](#) for current fees.

Revenue: 0262010000

Drug Sample Distributor Registration (Legend Drug) Application

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

Check One:

- ☐ Out-of-State. Date of last inspection _____
(Provide copy of last inspection report.)
- ☐ In-State. (Complete legend drug sample distributors report located on the last page of application packet.)

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 (if applicable)

Enter DEA # _____

3. Key Individuals

Contact Person

Name _____

Phone (enter 10 digit #) _____

Email Address: _____

Title _____

4. 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 (enter 10 digit #)	Title

Change of Ownership Information

Previous Name of Legal Owner _____

Previous Name of Facility _____

Previous Pharmacy License # _____

Effective Date of Ownership Change _____

Physical Address _____

4. Additional Information (Continued)

24 hr Phone Numbers: Day _____ Night _____

Note: If you do not have a 24-hour phone available to respond to inquiries regarding drug sample distribution, complete the [Legend Drug Sample Distributors Report](#) (form DOH 690-077). On that form, you must list the addresses for the sites in Washington at which drug samples are stored. The listing must include the names, addresses, and phone numbers of all persons who are responsible for the distribution of such samples.

Do individual representatives distribute controlled substance samples?

☐ Yes (If yes, you must enter DEA # in Section 2.)

☐ No

Frequency of your reports to DEA for ARCOS program: ☐ Quarterly ☐ Monthly ☐ Other (specify) _____

Date next report is due to DEA _____

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

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Pharmacy Quality Assurance Commission
Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Legend Drug Sample Distributors Report

The persons listed below either distribute legend drug samples to practitioners in Washington or are responsible for such distribution.				Type of Storage (check appropriate box)
Name				<input type="checkbox"/> Residence <input type="checkbox"/> Mini-Storage <input type="checkbox"/> Centralized Distribution Point in WA
Address				
City	State	Zip Code	Phone (enter 10 digit #)	
Name				<input type="checkbox"/> Residence <input type="checkbox"/> Mini-Storage <input type="checkbox"/> Centralized Distribution Point in WA
Address				
City	State	Zip Code	Phone (enter 10 digit #)	
Name				<input type="checkbox"/> Residence <input type="checkbox"/> Mini-Storage <input type="checkbox"/> Centralized Distribution Point in WA
Address				
City	State	Zip Code	Phone (enter 10 digit #)	
Name				<input type="checkbox"/> Residence <input type="checkbox"/> Mini-Storage <input type="checkbox"/> Centralized Distribution Point in WA
Address				
City	State	Zip Code	Phone (enter 10 digit #)	
Name				<input type="checkbox"/> Residence <input type="checkbox"/> Mini-Storage <input type="checkbox"/> Centralized Distribution Point in WA
Address				
City	State	Zip Code	Phone (enter 10 digit #)	
Name				<input type="checkbox"/> Residence <input type="checkbox"/> Mini-Storage <input type="checkbox"/> Centralized Distribution Point in WA
Address				
City	State	Zip Code	Phone (enter 10 digit #)	
Name				<input type="checkbox"/> Residence <input type="checkbox"/> Mini-Storage <input type="checkbox"/> Centralized Distribution Point in WA
Address				
City	State	Zip Code	Phone (enter 10 digit #)	
Name				<input type="checkbox"/> Residence <input type="checkbox"/> Mini-Storage <input type="checkbox"/> Centralized Distribution Point in WA
Address				
City	State	Zip Code	Phone (enter 10 digit #)	

(You may copy this form if necessary)

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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](#)

[Drug Sample Laws, RCW 69.45](#)

[Pharmacy Rules, WAC 246-945](#)

Online

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