

2014 WHOLESALER CLASS I ANNUAL RENEWAL – Supplemental Information Form

Oregon Board of Pharmacy
800 NE Oregon Street, Suite 150
Portland OR 97232



Please PRINT or TYPE **WARNING:** ORS 475.135(1)(e) and ORS 689.405(1) The furnishing of false information is grounds to deny registration.

Business Name (DBA) _____

Corporation Name _____

Parent Company Name (If applicable) _____

License Number _____ Federal Tax ID # _____

Location Address _____

City, State, Zip _____

Phone Number () - FAX # () -

Is the address listed above the primary mailing address for license and renewals? [] Yes [] No

If No, please complete the mailing information below:

Mailing Address _____

City, State, Zip _____

Contact Person _____ Title _____ Contact Phone _____

Email Address: _____

Officers or Members Information

Complete this section for all corporate officers or members. You may provide an attachment with this information.

1. Name _____

Title _____

Address _____

City, State, Zip _____

Phone Number _____

Email Address _____

2. Name _____

Title _____

Address _____

City, State, Zip _____

Phone Number _____

Email Address _____

Designated Representative of Facility

Designated Representative requirements are in Oregon Administrative Rule 855-065-0009. Note: You must notify the Board in writing of a change in Designated Representative within 15 days of the change.

Designated Representative Information:

Name _____

Address _____

City, State, Zip _____

Phone Number _____

Fax _____

Email Address _____

Normal Business Hours of Facility _____

Please attest to of the following by checking the boxes on the left:

[] The Designated Representative is the Designated Representative of only one wholesale distributor or has an exception approved by the Board.

[] The Designated Representative is involved in and aware of the daily operations of the wholesale distributor.

[] The Designated Representative is physically present at the wholesale distributor during normal business hours.

Attestation and Signature

Attest to ALL of the following statements by checking the box next to the statement.

- Prior to distributing any pharmaceutical product into Oregon, we verify that the product's manufacturer is licensed in Oregon.
- Prior to shipping any pharmaceutical product into or within Oregon, we verify that the recipient is licensed in Oregon.
- We are aware that if we physically manufacture any drugs or prescription devices a Manufacturer Registration is required in addition to a Wholesaler Registration.
- We are aware that all Wholesalers must complete a **Self-Inspection Report** by September 1 annually. *This report form is available on our website and must be retained at the facility and be made available to the Board upon request. Do not send this report to the Board unless it is specifically requested.*

Check one of the following two options.

- This facility is **VAWD Accredited** through the **NABP**. *A copy of our accreditation certificate is enclosed.* If you have submitted an application to **NABP** mark pending below and indicate the date it was submitted.

Pending _____ Date: _____

-OR-

- We are located in Oregon or have been inspected within the last three years by a state whose inspection report has been approved by the Oregon Board of Pharmacy. *A copy of our inspection report and a copy of our \$100,000 Surety Bond or Irrevocable Letter of Credit are enclosed (if applicable).*

Check the applicable answers below.

Yes **No** – Are you a Third-Party Logistics Provider? A Third-Party Logistics Provider means an entity that contracts with a manufacturer to provide or coordinate warehousing, distribution, or other services on behalf of the manufacturer, but does not take title to the drug or have general responsibility to direct the sale or disposition of the drug.

Yes **No** - Since the date of your last renewal has disciplinary action ever been taken, or is any such action currently pending against any of the persons listed on this application, by any State or Federal Authority in connection with a violation of any federal or state drug law or regulation? If "yes", attach a detailed explanation of the incident and describe any penalty incurred.

You MUST attest to all of the above statements and answer the disciplinary action statement or your renewal is not complete and cannot be processed.

The Designated Representative signing this document acknowledges reading and understanding the responsibilities of a Designated Representative in Oregon Administrative Rule 855-065-0009. Further, the undersigned hereby states that all the information contained in this application for renewal is true and correct, that they have read and are familiar with the pharmacy laws and rules of the Oregon Board of Pharmacy, and that such provisions of the law will be faithfully observed.

Print or Type Name Designated Representative

Signature of Designated Representative

Date