Pharmaceutical Wholesaler License Application Packet

Contents:

Note: The Commission will no longer license entities exclusively engaged in third-party logistics, as defined in 21 U.S.C. § 360eee(22). While the Commission will not license third-party logistics providers (3PLs), 3PLs are federally required to report annually to the FDA.

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 civil.rights@doh.wa.gov

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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.

All virtual manufacturers must provide a copy of the contracted manufacturer's last state, FDA, or approved third party inspection report

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 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.

☐ **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.

Signature of responsible person for facility.

Date signed.

Print name of responsible person for facility.

Print title of responsible person for facility.

Washington State Department of HEALTH

Date Stamp Here

Check all that apply (See online fee page)

- ☐ Full-line Drug Wholesaler
- ☐ Drug Wholesaler Over-the-Counter Only (over the counter or non-prescription drugs only)
- ☐ Drug Wholesaler (Export)
- ☐ Drug Wholesaler (Export Non-profit)
- ☐ Controlled Substance (CSA)

Note: Check the CSA box if you are applying for CSA in addition to your wholesale license.

Revenue: 0262010000

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

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 #)	
Mailing Address (If different than physical address)			
City	State	Zip Code	County

2. Facility Specific Information

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

☐ Distribution Center for Multiunit (Chain) ☐ Hospital Corporation Distribution Center ☐ Reverse Distributor
☐ Wholesaler ☐ Out of State Manufacturer ☐ Out of State Virtual Manufacturer ☐ Virtual Wholesaler

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

☐ Community Pharmacies ☐ Veterinarians ☐ Physicians or Other Practitioners
☐ Hospital Pharmacies ☐ Hospitals ☐ Wholesalers
☐ Retail Outlets (Shopkeepers) ☐ Other (describe)_____

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

☐ List 1 Chemicals ☐ Legend (Prescription Drugs) ☐ Veterinary Drugs
☐ Controlled Substances—Schedule(s) _____ ☐ Over-the-counter Medications
☐ 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	**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.		
3. Has any owner or officer ever been found guilty of a drug, controlled substance, or moral turpitude violation?	☐	☐
If yes, attach an explanation in detail, providing the circumstances, places, dates, and outcomes.		

3. Contact Information

Name of Responsible Person for Facility	Phone (enter 10 digit #)	Email Address
Title of Responsible Person for Facility		
Contact Person for Regulatory Issues	Phone (enter 10 digit #)	Email Address
Title of Contact Person for Regulatory Issues		

4. Additional Information

Date of Incorporation	Corporate Number	State of Corporation

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.

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

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

Signature of Responsible Person for Facility

Date

Print Name of Responsible Person for Facility

Print Title of Responsible Person for Facility

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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 246-945

Online

Pharmacy Quality Assurance Commission, Web Page