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
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

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

Contact us:

360-236-4700

Washington State Department of Health

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.

Washington State Department of Health

Date Stamp Here

Fees (check all that apply)
☐ Without controlled substance.................. Fee
☐ With controlled substance....................... Fee
All application fees are nonrefundable
You can check the online **fee page** for current fees.

Revenue: 0262010000

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		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

For Office Use Only

License # ______________________________________ Issue Date ________________________________

2. Facility Information

Drug Enforcement Administration (DEA) # ______________________________

Background Questions	Yes	No
1. Have any applicants, partners, or managers had a suspension, revocation, denial, 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 (including samples)? .... If yes, list and explain on a separate sheet of paper.	☐	☐

Pharmacist Consultant Name	License Number	Date of Appointment

3. Contact Information

Contact Person Name	Title	Phone (enter 10 digit #)	Email Address

4. Additional Information

Date of Incorporation	Corporate Number	State of Corporation

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.

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

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 246-863**

Health Care Entity Rules .... **WAC 246-904**

On-Line

AIDS Training Resources ....**Reference Page**

Pharmacy Quality Assurance Commission..**Web Page**