

## **Pharmaceutical Wholesaler License Application Packet**

### **Contents:**

1. 690-169...Contents List/Mailing Information ..... 1 page
2. 690-170...Application Instructions Checklist..... 2 pages
3. 690-171...Pharmaceutical Wholesaler License Application..... 3 pages
4. RCW/WAC and Online Website Links..... 1 page

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](mailto:civil.rights@doh.wa.gov)

(This page intentionally left blank.)

## 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.

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

- |  |   |   |
|--|---|---|
| <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 #)	
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 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

(This page intentionally left blank.)





## **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](#)