

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:

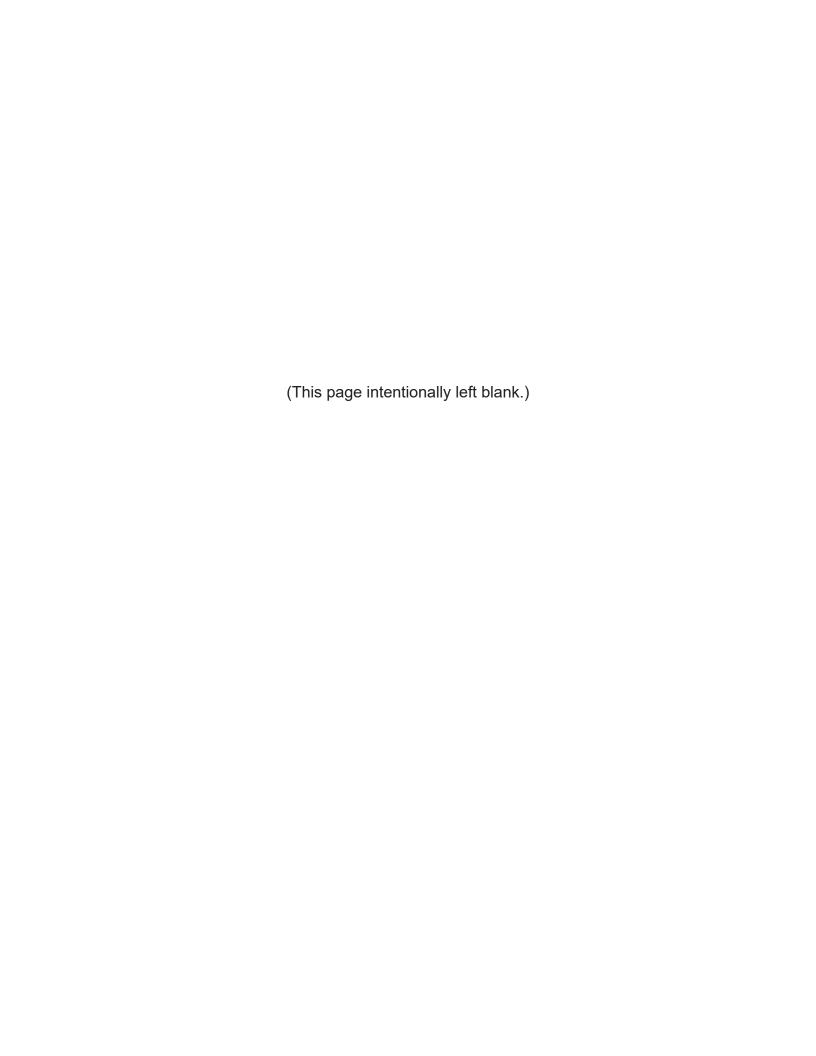
Department of Health P.O. Box 1099 Olympia, WA 98507-1099 Send other documents not sent with initial application to:

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.





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 (URL#): Enter your Washington State URL

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.

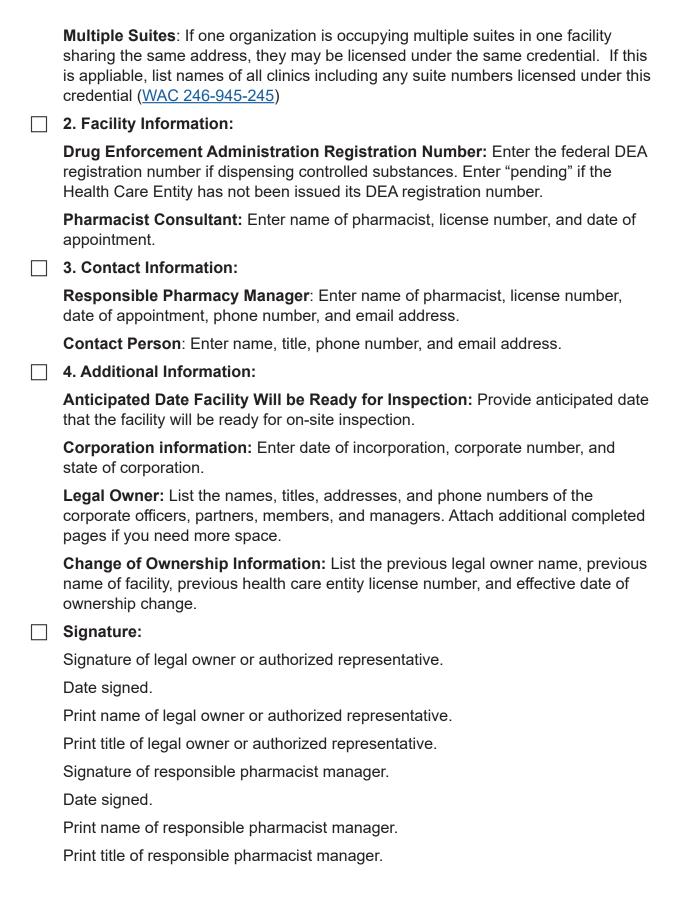
Physical Address: Enter the agency's physical street location including city, state, zip code, and county.

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.

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Date Stamp Here

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

Revenue: 0262010000						
Pharmacy He	alth	Care En	tity Licens	se Application		
This is for: ☐ New ☐ Change of 0	Owners	ship 🗌 Ch	ange of Location	Current License #		
☐ Name Change Only—			_	• • • • • • • • • • • • • • • • • • • •		
Update Clinics - Curre						
Please note: For any modifications o	r remo	dels, please s	ubmit a <u>Facility F</u>	Remodel Application.		
Check One						
☐ Association	Li	mited Partners	ship [Sole Proprietor		
☐ Corporation	\square M	unicipality (Cit	ty) State Government Agency			
☐ Federal Government Agency		unicipality (Co	unty)	Tribal Government Agency		
☐ Limited Liability Company	☐ No	on-Profit Corp	oration [] Trust		
☐ Limited Liability Partnership	□ Pa	artnership				
1. Demographic Informa	tion					
UBI#		Fe	ederal Tax ID (FEII	N) #		
			`			
Legal Owner/Operator Name						
Legal Owner/Operator Name						
Mailing Address						
City		State	Zip Code	County		
City		State	Zip Code	County		
Phone (enter 10 digit #)	Fax (e	nter 10 digit #)		Email Address		
,	,	,				
Facility/Agency Name (Business name	as adv	ertised on signs	s or Web site)			
. ac, go						
Physical Address						
Thyereal / Idail eee						
City State			Zip Code	County		
Facility Phone (enter 10 digit #) Fax (enter 10 dig				Email Address:		
. acmy (c.m a.g)			2			
Mailing Address (If different than physical address)						
maning / tadi 555 (ii diliofont than physical addi 555)						
City State			Zip Code	County		
		1	i i	1		

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If one organization is occupying multiple suites in one facility sharing the same address, they may be licensed under the same credential. If this is appliable, list names of all clinics including any suite numbers licensed under this credential (<u>WAC 246-945-245</u>). Please provide the number of medication locations within each suite.

	Number of	Number of
	Medication	Medication
	Locations	Locations
1.	16.	
2.	17.	
3.	18.	
4.	19.	
5.	20.	
6.	21.	
7.	22.	
8.	23.	
9.	24.	
10.	25.	
11.	26.	
12.	27.	
13.	28.	
14.	29.	
15.	30.	

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2. Facility Information									
Drug Enforcement Administration (DEA) #									
Background Questions								Yes	s No
Have any applicants, partners, or managers had a suspon of a professional license?					ension, revocation, denial, or restriction				
If yes, list and explain on	a sep	parate sheet of pa	aper.						
	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	a sep	parate sheet of pa	aper.						
3. Contact Informa	atio	n							
Responsible Pharmacy Mana	ager	Name	License N						
Phone (enter 10 digit number)			Email Address						
Contact Person Name			Title				Phone (enter 10 digit number)		
Email Address									
4. Additional Infor		4ion							
Anticipated Date Facility Will be			n:						
Date of Incorporation Corporate Num			State of Corporation				n		
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	Add	Address			Phone (enter 10 di		10 digit #)	Title	
Change of Ownership Information									
Name of Previous Legal Owner				Name of Previous Health Care Entity					
Previous Health Care Entity License Number				Effective Date of Ownership Change					

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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				
Signature of Responsible Pharmacist Manager	Date				
Print Name of Responsible Pharmacist Manager	Print Title				

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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

Pharmacy Rules, WAC 246-945

Online

Pharmacy Quality Assurance Commission, Web Page