

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:

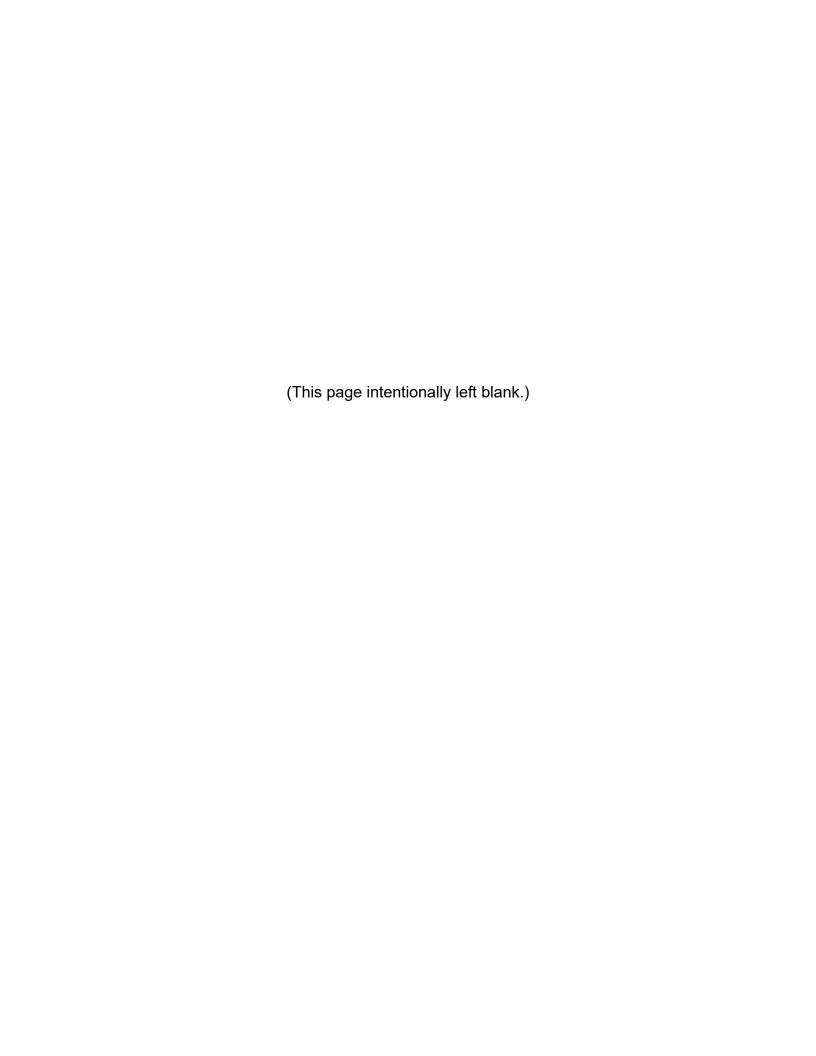
Department of Health P.O. Box 1099 Olympia, WA 98507-1099 Send other documents not sent with initial application to:

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 doh.information@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:
Haifarm Business Identifier Number (IIDI #). Enter your Machineter State IIDI

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.

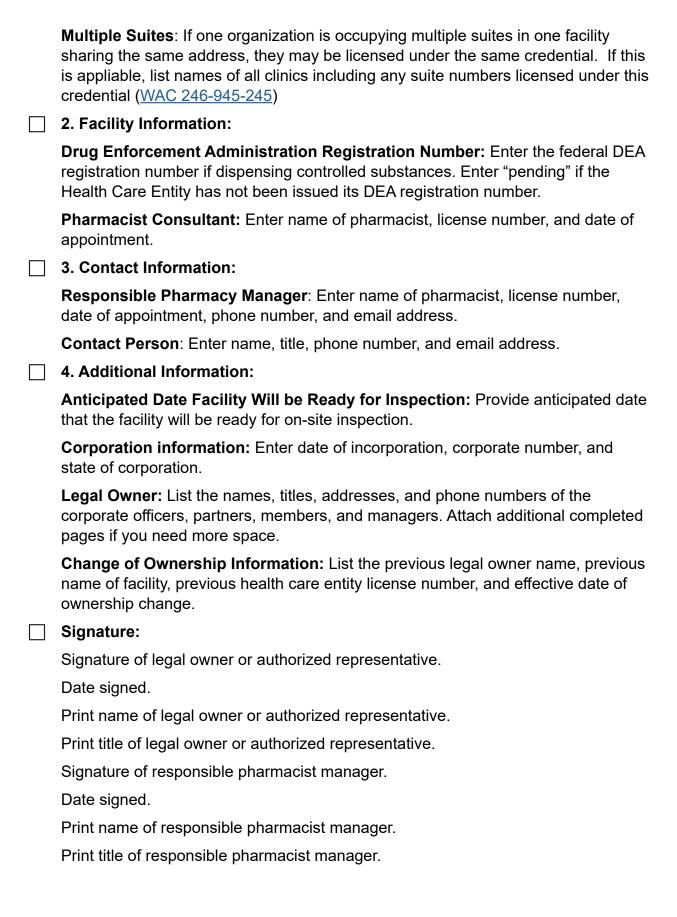
Physical Address: Enter the agency's physical street location including city, state, zip code, and county.

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

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 Update Clinics - Current License # Please note: For any modifications or remodels, please submit a <u>Facility Remodel Application</u> .						
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 Informa	tion					
UBI#			Federal Tax ID (FEIN) #			
Legal Owner/Operator Name						
Mailing Address						
City		State	Zip Code	County		
Phone (enter 10 digit #)	Fax (e	nter 10 digit #)		Email 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 (e	enter 10 digit #)		Email Address:		
Mailing Address (If different than physical address)						
City		State	Zip Code	County		

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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 o
	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 Administra	ation	(DEA) #								
Background Questions								Ye	s	No
Have any applicants, part	Have any applicants, partners, or managers had a suspension, revocation, denial, or restriction of a professional license?									
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 sep	parate sheet of pa	aper.							
3. Contact Informa	atio	n								
Responsible Pharmacy Man	ager	Name	License N	lum	ber		Date of A	ppointment		
Phone (enter 10 digit number)			Email Add	dres	S					
Contact Person Name			Title				Phone (enter 10 digit number)			
Email Address										
4. Additional Infor										
Anticipated Date Facility Will be Ready for Inspection:										
Date of Incorporation Corporate Num			ber State of Corporation			n				
Legal Owner Information-	–atta	ach additional	complete	d p	ages	if you n	eed more	space.		
List names, addresses, phone numbers, and titles of corporate officers, partners, members, and managers.										
Name	Name Address		Phone (enter			ne (enter	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