Pharmacy Health Care Entity License Application Packet

Contents:

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 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.

Multiple Suites: 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 (WAC 246-945-245)

☐ **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:**

Responsible Pharmacy Manager: Enter name of pharmacist, license number, date of appointment, phone number, and email address.

Contact Person: Enter name, title, phone number, and email address.

☐ **4. Additional Information:**

Anticipated Date Facility Will be Ready for Inspection: Provide anticipated date that the facility will be ready for on-site inspection.

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 _____

☐ Update Clinics - Current License # _____

Please note: For any modifications or remodels, please submit a Facility Remodel Application.

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	
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

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 (WAC 246-945-245). Please provide the number of medication locations within each suite.

	Number of Medication Locations		Number of Medication 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.	

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.		

3. Contact Information

Responsible Pharmacy Manager Name	License Number	Date of Appointment
Phone (enter 10 digit number)	Email Address	
Contact Person Name	Title	Phone (enter 10 digit number)
Email Address		

4. Additional Information

Anticipated Date Facility Will be Ready for Inspection:		
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

Name of Previous Legal Owner	Name of Previous Health Care Entity
Previous Health Care Entity License Number	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 246-945

Online

Pharmacy Quality Assurance Commission, Web Page