

GOVERNMENT OF THE DISTRICT OF COLUMBIA Department of Health Health Regulations and Licensing Administration Pharmaceutical Control 899 North Capitol St. 2nd floor Washington, D.C. 20002

| JSE ONLY! | | | | | |
|------------------------|--|--|--|--|--|
| Application Complete: | | | | | |
| D NO | | | | | |
| Approved Registration: | | | | | |
| □ NO | | | | | |
| | | | | | |

FOR OFFICIAL USE ONLY!

DATE: ______ LIC/REG NO: _____ INITIALS: _____

PHARMACY LICENSURE APPLICATION

| RETURN COMPLETED APPLICATION WITH REGISTRATION FEE MADE OUT TO "D.C. TREASURER" TO 899 N. Capitol St, NE 2 nd Floor, WASHINGTON, DC 20002 | | | | | | | |
|---|--------------------|---|---------------------|--|------------------------------------|--------------------------------------|--|
| 22 DCMR 1902.1 Licenses shall be issued for the following categories of pharmaciesexcept for nonresident pharmacies, which shall be required to register with the Department | | | | | | | |
| 22 DCMR 1902.2 A retail chain pharmacy with locations both in and outside of the District of Columbia (DC) shall obtain (a) a license for each location within DC and A registration pursuant | | | | | | | |
| of §1903 for each location outside DC | | | | | | | |
| CHECK ONE: | | CHECK ONE: | | | CHECK ONE: | | |
| Pharmacy Category | | DC Resident Pharmacy | | | Nonresident Pharmacy | | |
| Retail/Community Pharmacy | | (Biennial Licensing Fee: \$90 | | | (Biennial Registration Fee: \$900) | | |
| Nuclear Pharmacy | | Initial (Proposed date of | opening |) | Initial (Proposed date of opening) | | |
| Institutional Pharmacy | | Renewal (License No: | |) | | ewal (Registration No:) | |
| Special or Limited Use Pharmacy | | Change of Ownership | | | | inge of Ownership | |
| Nonresident Pharmacy | | Change of Pharmacy Na | | | | inge of Pharmacy Name | |
| | | Change of Pharmacy Lo | | | | inge of Pharmacy Location | |
| | | Change of Pharmacist-ir | n-Charge | | | inge of Pharmacist-in-Charge | |
| I. Changes to Current Pharmacy Status | | | | | | | |
| All pharmacies must report any change of owners | hip, name, locatio | n, or pharmacist-in-charge in writin | g to the Department | | | | |
| CHANGE OF OWNERSHIP | | F PHARMACY NAME | CHANGE OF PH | | ATION | CHANGE PHARMACIST-IN-CHARGE | |
| Proposed Effective Date: | Proposed Effe | | Proposed Effective | | <u> </u> | Proposed Effective Date: | |
| Pharmacy License/Registration Number | Pharmacy Lice | nse/Registration Number | Pharmacy License/F | Registration Nui | mber | Pharmacy License/Registration Number | |
| | | | | | | New Pharmacist-in-Charge Name | |
| Previous Owner Name | Draviaua Dhan | maay Nama | Draviaua Dharmaay | Address | | | |
| Previous Owner Name | Previous Phar | nacy name | Previous Pharmacy | Address | | Pharmacist License Number | |
| | | | | | | Pharmacist License Number | |
| New Owner Name | New Pharmacy Name | | New Pharmacy Add | 1000 | | | |
| New Owner Name | New Fliatiliac | y Name | New Fliatiliacy Aud | 1635 | | Pharmacist Signature | |
| | | | | | | Filamacist Signature | |
| | | | | | | | |
| II. District of Columbia Resident Pharmacy Onl | v. (Complete thi | s section then go to page 3) | | | | | |
| Pharmacy Name | | Pharmacy Street Address | | | Area Code | and Telephone Number | |
| Thannacy Name | | Thanhacy Street Address | | | Alca Oouc | | |
| | | | | | | | |
| Pharmacist-In-Charge (PIC) | | City | State | Zip | Area Code | and Fax Number | |
| · ···································· | | , | | | | | |
| | | | | | | | |
| PIC License Number | | Certificate of Occupancy Number | | Expected Hours of Operation (Weekdays) | | | |
| | | (Please submit a copy of Certificate of Occupancy if this is an | | • | | | |
| | | initial application) | | | | | |
| Signature of PIC | | | | Expected Hours of Operations (Weekends/Holidays) | | | |
| | | | | | - | · · · · | |
| Curre | | Current License Number, if ap | plicable | | | | |
| | | | | Email Address | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

| III. Nonresident Pharmacy Only | | | | |
|--|---|---|--|--|
| Pharmacy Name | Pharmacist-in-Charge (PIC) | PLEASE WRITE THE REQUESTED INFORMATION AND SUBMIT LEGIBLE COPIES OF THE FOLLOWING: | | |
| Pharmacy Street Address | PIC Pharmacy License Number State of Licensure (Submit copy of PIC pharmacy license) | Certificate of Occupancy Number: | | |
| City State Zip | Affidavit | Pharmacy License Number in resident state: | | |
| Area Code and Telephone Number | I certify that I have read and understand the pharmacy and drug laws and regulations of DC, and I have made the pharmacy and drug laws and regulations of DC available to all pharmacists | DEA Registration Number: | | |
| Area Code and Fax Number | working in the nonresident pharmacy | ☐ Most recent pharmacy inspection report: | | |
| Toll-Free Telephone Number for Consultation | Pharmacist-in-Charge Signature | | | |
| | Date | | | |
| 22 DCMR 1903.8(d)(4) List of Pharmacists practicing at this | 22 DCMR 1903.8(d)(5) List of resident agents located within DC | 22 DCMR 1903.8(h) List of website address(es) and | | |
| pharmacy check here if list is attached to the application | designated to accept service of process check here if list is attached to the application | domain registration(s). check here if list is attached to the application | | |
| Pharmacist name License Number | Name Title | | | |
| | Address | | | |
| | | | | |
| | Name Title | | | |
| | Address | | | |
| | | | | |
| | Name Title | | | |
| | Address | | | |
| | | | | |
| Illa. Please Answer the Following Questions | ermit in good standing in the state in which it is located? | | | |
| | | | | |
| 2. Does the nonresident pharmacy have the ability to provide to the DC Department of Health ("Department") a record of prescription orders dispensed to a DC resident no later than three (3) business days after the time the Department requests the record? | | | | |
| Is the nonresident pharmacy solely internet-based or operates primarily as an internet-based pharmacy? If "YES", please submit proof of: | | | | |
| Certification by the Verified Internet Pharmacy Practice Site Program of the National Association of Boards of Pharmacy, or other national certification program for internet pharmacies for each website and domain registration | | | | |
| Proof of registration in good standing in DC as a foreign corporation | | | | |
| 4. Does the nonresident pharmacy have a toll-free telephone number disclosed on a label affixed to each container of drugs or medical devices dispensed to patients in DC? PLEASE SUBMIT A COPY OF THE LABEL SHOWING THE TOLL-FREE NUMBER | | | | |
| 5. Is the nonresident pharmacy in compliance with the laws and regulations regarding confidentiality of prescription records in the state in which it is located, and if there are no such laws in that state, then is the pharmacy in compliance with the confidentiality laws and regulations of DC? | | | | |

| IV. Proprietor Information Proprietor Type (CHECK ONE) INDIVIDUAL CORPO | RATION PARTNERSHIP UNINCORPORATED INDIVID | UAL OTHER: | | | | | |
|--|---|--|--|--|--|--|--|
| Name of Individual, Corporation, Partnership, Other | NAME AND ADDRESS FOR PRINCIPAL OFFICERS President of Corporation/Partnership | Treasurer of Corporation/Partnership | | | | | |
| Billing Street Address | | | | | | | |
| City State Zip | Vice President of Corporation/Partnership | Other Principal Corporate Officer | | | | | |
| Is the corporation in good standing with DC or the state of incorporation? YES NO Has any principal corporate officer ever been convicted of a felony involving drugs? YES NO If the answer to this is "YES", please submit a statement of explanation with this application V. Please Answer the Following Questions | Secretary of Corporation/Partnership | State of Incorporation Year Incorporated | | | | | |
| 1. Does your pharmacy facilitate the dispensing, shipping, mailing, delivery, or distribution of prescription drugs or devices from any jurisdiction outside of the United States to DC residents? DC residents? YES NO If the answer to this is "YES", please submit a statement of explanation with this application | | | | | | | |
| 2. Did you include your licensing/registration fee? | | | | | | | |
| 3. Did you include copies of all required documents? YES NO | | | | | | | |
| VI. Certification Form | | | | | | | |
| TO THE APPLICANT: Please read carefully and completely before signing. A false statement on this certification requires that the Department proceed immediately to revoke the license or permit for which you are now applying and fine you \$1000.00. This certificate is required by the "CLEAN HANDS BEFORE RECEIVING A LICENSE OR PERMIT ACT OF 1996". (Effective May 11, 1996, D.C. Law 11-118, D.C. Code §47-2861 et seq.) | | | | | | | |
| I,, certify that as of, I do not owe more than \$100.00 to the District of Columbia government as a result of: | | | | | | | |
| Fines, penalties or interest assessed pursuant to the Litter Control Administration Action of 1985, effective March 25, 1986 (D.C. Code § 6-2901 et seq.); Fines, penalties or interest assessed pursuant to the Illegal Dumping Enforcement Act of 1994, effective May 20, 1994 (D.C. Law 10-117; D.C. Code § 6-2911 et seq.); Fines, penalties or interest assessed pursuant to the Department of Consumer and Regulatory Affair Civil Infractions Act of 1985, effective October 5, 1986 (D.C. Law 6-42; D.C. Code § 6-2701 et seq.); or Past due taxes. | | | | | | | |
| I understand that if I knowingly falsify this Certification, the Department will move to revoke the license or permit for which I am applying, and to fine me \$1,000.00. I further understand that the Department may conduct an investigation to ascertain the veracity of this certification. I understand that this Certification is now required as documentation to accompany my application for a license or permit, and that by completing this Certification, I am not guaranteed that my license or permit will be approved. | | | | | | | |
| Signature of Applicant | | <u> </u> | | | | | |
| 22 DCMR 1902.5 It shall be unlawful for any person to furnish false or fraudulent information on an application for a license or registration. I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, ALL OF THE STATEMENTS MADE ARE TRUE, COMPLETE, AND CORRECT | | | | | | | |
| Signature of Applicant | | Date | | | | | |
| | | | | | | | |