

12 Companies who do business in New York State must have a registered agent for service of process in New York State, which is the contact person or agent to receive legal papers when a corporation is served for a legal reason.

Name of resident agent for service of process in New York: _____

Agent's phone number: _____

13 This wholesaler will ship to: (check all that apply)

- Pharmacies Dentists Hospitals without pharmacies
- Hospitals Veterinarians Clinical/Surgical Centers
- Physicians Other licensed healthcare practitioners (Please specify) _____
- _____

14 VAWD Accreditation

The National Association of Boards of Pharmacy's (NABP) Verified Accredited Wholesale Distributors (VAWD) accreditation is designed to protect the public from counterfeit drugs entering the U.S. drug supply.

Has your facility obtained VAWD accreditation?

- Yes VAWD Accreditation number _____ Accreditation date _____
- No Applied for VAWD Accreditation on _____
- No Have not yet applied for VAWD Accreditation

15 Type of products this wholesaler will handle: (check all that apply)

- Prescription drugs (excluding medical gases)
- Nonprescription drugs
- Veterinary drugs
- Vitamins
- Crude drugs, botanicals, medicinal chemicals
- Serums, toxins, vaccines and similar biologicals
- Devices, hypodermic syringes, needles, etc.
- Compressed medical gasses
- Medical cosmetics
- Other (Please specify) _____
- _____

16 Days and hours of operation of the wholesaler: _____

17 All pre-registration correspondence should be mailed to:

- Wholesaler address indicated on page 1 of this application.
- Different address** than wholesaler. *All pre-registration correspondence should be mailed to the following address.*

Number and street: _____

City: _____ State: _____ Zip Code: _____

18 Contact person to clarify information provided on this application:

Name: _____

Telephone: _____ Fax: _____ E-mail: _____

19 Submit Certification/Verification of License/Permit/Registration From Your Resident State.

Members, Partners, Owners or Corporate Officers

First Name (please print)	
Last Name (please print)	
Signature	Date / /
Title (please print)	

First Name (please print)	
Last Name (please print)	
Signature	Date / /
Title (please print)	

First Name (please print)	
Last Name (please print)	
Signature	Date / /
Title (please print)	

First Name (please print)	
Last Name (please print)	
Signature	Date / /
Title (please print)	

First Name (please print)	
Last Name (please print)	
Signature	Date / /
Title (please print)	

First Name (please print)	
Last Name (please print)	
Signature	Date / /
Title (please print)	

Verification With Acknowledgment (Notarization required.)**Verification**

By signing below, I verify that the information on this application is true and accurate. I further verify that the wholesaler applicant has complied in the past and will comply in the future with all lawful requests for information from the regulatory agencies of all states in which it is licensed or registered, including New York State. I further certify that the wholesaler applicant will maintain records of drugs distributed or wholesaled in New York State for five years, in a manner which makes these records readily retrievable and identifiable from other business records of the wholesaler. I also verify that I have received a copy of the New York State's, "Pharmacy Guide to Practice," and I have read it and understand my responsibilities to the New York State Board of Pharmacy and the New York State Education Department. In addition, if distributed or wholesaled drugs are controlled substances, they shall be distributed or wholesaled pursuant to Article thirty-three of the Public Health Law and Part 80 of the Department of Health's Commissioners Regulations, Article thirty-three and Part 80 can be accessed at www.health.state.ny.us/nysdoh/narcotics. Questions on controlled substances should be directed to the New York State Department of Health's Bureau of Controlled Substances at 518-402-0707.

 Authorized signature (Member, Partner, Owner, Corporate officer or Other authorized person)

Date: _____ / _____ / _____
 Month Day Year

 Printed Name

 Title

Notary

State of _____ County of _____

On the _____ day of _____ in the year _____ before me, the above, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

 Notary Public signature

 Notary ID number

Notary Stamp

Expiration date _____ / _____ / _____
 Month Day Year

- To assure prompt filing, please be sure to complete all portions of this **application**
- Send a fee of \$825*
- Please make check or money order payable to the **New York State Education Department**. DO NOT SEND CASH. Payments made outside the United States should be made by check or draft on a United States bank in United States currency.

**New York State Education Department
 Office of the Professions
 Board of Pharmacy
 2nd Floor West Wing
 89 Washington Avenue
 Albany, NY 12234**

*An application fee is required for "Registration of Wholesaler" and "Transfer of Ownership."

* NO FEE is required for Change of Location or Name Change.