M/W INFORMATION FORM

PART I (Print in Black Ink)

(check one):  ☐ Manufacturer  ☐ Repacker of Drugs  ☐ Repacker of Medical Gases  ☐ Wholesaler

1 Name of owner/corporation under which registration has been issued or is sought:

2 Trade Name (if applicable):

3 M/W Address:

   Street and Number
   City
   State
   County
   Zip Code

4 Complete ONE of the Following:
   A.  ☐ New Registration  Proposed date of opening:     mo.     day     yr.
   B.  ☐ Transfer of Ownership  Proposed date of transfer:     mo.     day     yr.

   Name of previous registrant: ________________________________
   Registration number: ________________________________

   C.  ☐ Change of location  Proposed Date of change:  mo.     day     yr.

   Previous address: ________________________________

   D.  ☐ Renovation  Proposed date of renovation:     mo.     day     yr.

   E.  ☐ Update/Other  ________________________________

5 Has the applicant applied for or been issued registration at any other location in this state by this department?  ☐ Yes  ☐ No

   If yes, please list the address and registration number. Use additional paper if necessary.

   Location and Address  Registration Number

   Does this applicant have a New York State registered pharmacy?  ☐ Yes  ☐ No

6 List Supervisor of this establishment  

REGISTRATION NUMBER: ________________________________
A. Nature of registration:

- Manufacturer/wholesaler  [ ] Yes  [ ] No
- Wholesaler only  [ ] Yes  [ ] No
- Repacker/wholesaler  [ ] Yes  [ ] No
- Medical gas repackager  [ ] Yes  [ ] No
- Repacker/wholesaler only  [ ] Yes  [ ] No

B. Daily schedule of hours the establishment will be opened. (list days of week and hours opened.)

C. List percent of business done with the following (must equal 100%):

- Domestic ________ %
- Foreign ________ %

8 Check ALL items distributed at this location.

- Prescription required drugs (human)  [ ]
- Medical Devices  [ ]
- Prescription required drugs (animal)  [ ]
- Hypodermic syringes and needles  [ ]
- Controlled substances  [ ]
- Over the counter drugs  [ ]
- Compressed medical gases/liquid  [ ]
- Cosmetics  [ ]
- Other __________________________________________________________________________________________________________

9 Building/Space Requirements

Has the following been adequately provided for? (check yes or no)

- Adequate lighting  [ ] Yes  [ ] No
- Appropriate sanitation  [ ] Yes  [ ] No
- Adequate space  [ ] Yes  [ ] No
- Necessary equipment  [ ] Yes  [ ] No
- Appropriate security  [ ] Yes  [ ] No
- Secure quarantine area  [ ] Yes  [ ] No
- Orderly stock control  [ ] Yes  [ ] No
- Free from insects, rodents, birds or vermin  [ ] Yes  [ ] No
- Drug areas secure from unauthorized entry  [ ] Yes  [ ] No
- Outside access well controlled and kept to a minimum  [ ] Yes  [ ] No
- Outside perimeter well lighted  [ ] Yes  [ ] No
- Alarm system for after hours  [ ] Yes  [ ] No
- Security system against theft and diversion  [ ] Yes  [ ] No
- Computer and electronic system security against theft and diversion  [ ] Yes  [ ] No
- Temperature control  [ ] Yes  [ ] No
- Humidity control  [ ] Yes  [ ] No
- Written policies and procedures for distribution/recalls etc.  [ ] Yes  [ ] No
- Hot and cold running water  [ ] Yes  [ ] No

Recording equipment used for temperature/humidity (check each):

- Manual  [ ] Yes  [ ] No
- Electromagnetic  [ ] Yes  [ ] No
- Electronic  [ ] Yes  [ ] No

Neighborhood (check type):

- Commercial  [ ] Yes  [ ] No
- Residential  [ ] Yes  [ ] No
- Both  [ ] Yes  [ ] No
- Reference books, etc.  [ ] Yes  [ ] No

FOR MANUFACTURERS AND REPACKERS ONLY

10 Supervision

Will all manufacturing and/or repacking be done under the personal supervision of a licensed pharmacist?  [ ] Yes  [ ] No

Supervisor’s who are not pharmacists shall meet the requirements as outlined in Section 63.6 (c)(1) of the regulations for registration and operation and of the establishments.

11 Do you have storage or manufacturing facilities for drug products at an address other than that indicated?  [ ] Yes  [ ] No

If your answer is “Yes,” indicated locations and explain:

_______________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________
_______________________________________________________________________________________________________________________

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### PART II

- Draw to scale the proposed establishment, indicating all dimensions. Show all doors and walls.
- Indicate areas for storage of drugs (drug bays).
- In red pen, indicate **R for refrigerator**.
- In red pen indicate **S for sink** that is located in the compounding and dispensing area.
- Outline the registered area in yellow.
- Indicate the premises adjacent to the buildings, offices and public thoroughfares.
- Name the adjacent businesses.
- **DO NOT SEND A BLUEPRINT, IT WILL BE DISCARDED.**

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<thead>
<tr>
<th></th>
<th>Total registered area</th>
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<th></th>
<th>Indicate Scale</th>
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PART III

Contact person to clarify information provided on this application:

Name: _______________________________________________________________________________________________________

Phone: _______________________________________________________________________________________________________ 

Fax: _________________________________________________________________________________________________________

Email address: ________________________________________________________________________________________________

PART IV: ATTESTATION

I affirm that all information submitted to the Board of Pharmacy is true. I am familiar with the laws, rules and regulations which govern the distribution of drugs and/or devices in New York State and with the Title 21 Code of Federal Regulations Part 205. I further understand that manufacturers, repackers and wholesalers may only sell drugs and/or devices to those purchasers authorized by law to receive them, and that records of the receipt and disposition of all drugs and/or devices shall be maintained for a period of five years and shall be available to the Department or any other authorized State or Federal agency for a period of not less than five years.

__________________________________________________________________________ ______________________________
Signature of applicant (Individual owner, partner, corporate officer, or *other authorized person)  Date

____________________________________________________________________________ ______________________________
Print Name  Date

*Power of attorney must be submitted for “other authorized person”

PART V: INSPECTION

Investigator’s Comments:
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

Signature – Investigator Office of Professional Discipline  Date

Print name

Return Directly to: New York State Education Department, Office of the Professions, New York State Board of Pharmacy, 89 Washington Avenue, Albany, NY 12234-1000

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