

8 How many hours a week is this establishment open for business? _____

9 Indicate classes of drugs manufactured, distributed, prepared, propagated, compounded, or processed and type of operation performed on each class.

CLASS OF DRUG (check applicable boxes)	TYPE OF REGISTRANT		
	MANUFACTURER	REPACKER	WHOLESALE
Prescription drugs (excluding medical gases)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Controlled Substances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nonprescription drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Veterinary drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crude drugs, botanicals, medicinal chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serums, toxins, vaccines and similar biologicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Devices, hypodermic syringes, needles, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compressed medical gases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicated cosmetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other – Specify _____			

10 Check all that apply: Is this location also registered as a: pharmacy manufacturer wholesaler repacker

If yes, name: _____

Does the applicant, individual owner, partner, officer or principal stockholder have financial or ownership interest in any New York State registered:
 pharmacy manufacturer wholesaler repacker

If yes, list any/all registered pharmacy/manufacturer/wholesaler/repacker that the applicant, individual owner, partner, officer or principal stockholder has interest in. (Attach a list if necessary.)

11 MORAL CHARACTER

The following questions pertain to any owner or corporate officer of the establishment or registrant.

- (a) Have you ever been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? YES NO
- (b) Are criminal charges pending against you in any court? YES NO
- (c) Has any licensing or disciplinary authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a professional license or certificate held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you? YES NO
- (d) Are charges pending against you in any jurisdiction for any sort of professional misconduct? YES NO
- (e) Have you ever willfully failed to provide records to any State Licensing authority or to Federal, State or Local law enforcement officials that are required by Federal, State or Local laws? YES NO

If yes, please explain _____

- (f) Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures? YES NO

NOTE: If you answer "Yes" to any questions (a) through (f), submit a letter giving complete explanation. Include copies of any court records, and if you possess one, a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

12 Give full name and requested information for each corporate officer, partner or member. Check the box of the new officer. USE ADDITIONAL SHEET IF NECESSARY.

Title _____ Last four digits of their Social Security Number:

Full name _____

Home address (street/city/state/zip) _____

Home telephone number: _____ Licensed Pharmacist? YES NO License # _____

Title _____ Last four digits of their Social Security Number:

Full name _____

Home address (street/city/state/zip) _____

Home telephone number: _____ Licensed Pharmacist? YES NO License # _____

Title _____ Last four digits of their Social Security Number:

Full name _____

Home address (street/city/state/zip) _____

Home telephone number: _____ Licensed Pharmacist? YES NO License # _____

Title _____ Last four digits of their Social Security Number:

Full name _____

Home address (street/city/state/zip) _____

Home telephone number: _____ Licensed Pharmacist? YES NO License # _____

13 a. Give full name and requested information for each owner or principle stockholder (owning 10% or more of corporate stock). Check the box of the new owner or stockholder. USE ADDITIONAL SHEET IF NECESSARY.

b. Is this a public owned corporation? YES NO. c. If this is a "not for profit" corporation, omit number 13.

Full name _____

Home address (street/city/state/zip) _____

Home telephone number: _____ Last four digits of their Social Security Number:

Licensed Pharmacist? YES NO License # _____ # of shares owned _____ shares owned _____%

Full name _____

Home address (street/city/state/zip) _____

Home telephone number: _____ Last four digits of their Social Security Number:

Licensed Pharmacist? YES NO License # _____ # of shares owned _____ shares owned _____%

Full name _____

Home address (street/city/state/zip) _____

Home telephone number: _____ Last four digits of their Social Security Number:

Licensed Pharmacist? YES NO License # _____ # of shares owned _____ shares owned _____%

Full name _____

Home address (street/city/state/zip) _____

Home telephone number: _____ Last four digits of their Social Security Number:

Licensed Pharmacist? YES NO License # _____ # of shares owned _____ shares owned _____%

UNDER TITLE 21 OF THE CODE OF FEDERAL REGULATIONS PART 250.6: THE STATE LICENSING AUTHORITY SHALL HAVE THE RIGHT TO DENY A LICENSE TO ANY APPLICANT IF IT DETERMINES THAT THE GRANTING OF SUCH LICENSE WOULD NOT BE IN THE PUBLIC INTEREST

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 ATTESTATION OF REGISTRANT

The undersigned affirms under penalty of perjury that the answers and statements that he/she has made in the above application are true and have been made and given with the intent of having the New York State Education Department and the New York State Board of Pharmacy rely on the truth thereof.

Print Name

Signature of registrant (Individual Owner, Partner, Corporate Officer, Member or *Other Authorized Person)

Date: ____ / ____ / ____

Title

*Power of attorney must be submitted.

16 ATTESTATION OF SUPERVISOR- PERSON NAMED IN ITEM 7

I hereby certify that I have full knowledge of my responsibilities and will discharge these responsibilities to the best of my ability and that I am not the supervisor of any other establishment registered by the Board of Pharmacy.

Print name

Signature of Supervisor

Date ____ / ____ / ____

17 Contact person to clarify information provided on this application.:

Name: _____

Telephone: () _____

Fax: () _____

E-mail: _____

Mail this form and fee of \$825 to: New York State Education Department, Office of the Professions, Board of Pharmacy, 2nd Floor West, 89 Washington Avenue, Albany, NY 12234. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.