The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
New York State Board of Pharmacy
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Department Use Only

☐ **P 2** **$170** **R E**

APPLICATION FOR ENDORSEMENT OF REGISTRATION OF MANUFACTURER, REPACKER AND/OR WHOLESALER OF DRUGS, PRESCRIPTION DEVICES OR MEDICAL GASES

This form may be used only for change of location and/or change of name authorized by the New York State Department of State

Registration Number: _____

Current Registered Period: _____

Expiration Date: _____

Date of Endorsement: _____

Approved: _____

Date: _____

1 **Name under which registration has been issued or is sought**

2 **Previous Address** Street and Number

City

State County

Zip Code

New Address Street and Number

City

State County

Zip Code

3 If a change in name, under what name is this establishment currently registered? Examine the registration certificate. Registration number: _____

_____ Date: _____ / _____ / _____

4

☐ Address change: _____ Date: _____ / _____ / _____

☐ Address change due to fire: Temporary _____ Permanent _____

☐ Other (explain): _____

_____

5 Trade name or assumed name of firm, if any. (Only assumed names registered with the County Clerk or New York State Department of State are acceptable)

_____

6 (a) Type of Registrant

- ☐ Manufacturer
- ☐ Repacker – Drugs
- ☐ Repacker – Medical Gases
- ☐ Wholesale (Distributor)

Type of Wholesaler

- ☐ Full Line
- ☐ Domestic Broker
- ☐ Import/Export Broker
- ☐ Reverse Distributor
- ☐ Specialty _____

(b) County _____

(c) Telephone _____

(d) Fax _____

(e) E-mail _____

(f) Federal Employer. ID # _____

7 Please indicate type of ownership:

☐ Individual ☐ Corporation for profit ☐ LLC for profit ☐ Partnership/LLP for Profit ☐ Government owned

☐ Corporation not-for-profit ☐ LLC not-for-profit ☐ Partnership/LLP not-for-profit

8 Name the supervisor who will be responsible for the supervision of the activities to be conducted by the registrant. **Note:** If name of supervisor is different from the registration certificate, also complete Forms M/W 104 and M/W 105 for a change.

Name of Supervisor _____

Date of Birth _____ / _____ / _____

If Pharmacist: License Number _____ State _____ Date of License _____ / _____ / _____

If Respiratory Therapist: License Number _____ State _____ Date of License _____ / _____ / _____

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

10 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	WHOLESALER
Prescription drugs (excluding medical gases)	☐	☐	☐
Controlled Substances	☐	☐	☐
Nonprescription drugs	☐	☐	☐
Veterinary drugs	☐	☐	☐
Vitamins	☐	☐	☐
Crude drugs, botanicals, medicinal chemicals	☐	☐	☐
Serums, toxins, vaccines and similar biologicals	☐	☐	☐
Devices, hypodermic syringes, needles, etc.	☐	☐	☐
Compressed medical gases	☐	☐	☐
Medicated cosmetics	☐	☐	☐
Other – Specify			

11 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.)

_____ Registration number: _____

_____ Registration number: _____

_____ Registration number: _____

12 **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."

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

☐ 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 # ______________

14 **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 14.

☐ 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

15 **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

16 **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.

17 **ATTESTATION OF SUPERVISOR– PERSON NAMED IN ITEM 8**

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 _____ / _____ / _____

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

Name: _____

Telephone: ( ) _____

Fax: ( ) _____

E-mail: _____

NO FEE REQUIRED FOR CHANGE OF NAME
$170 FEE REQUIRED FOR CHANGE OF LOCATION

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, Board of Pharmacy, 89 Washington Avenue, Albany, NY 12234-1000. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.