Virginia Department of
Health Professions
Board of Pharmacy

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Henrico, Virginia 23233
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www.dhp.virginia.gov/pharmacy

APPLICATION FOR A WHOLESALE DISTRIBUTOR PERMIT

Check Appropriate Box(es):

☐ New*	$750.00	☐ Change of Responsible Party	$125.00
☐ Change of Ownership	$125.00	☐ Change of Location or Remodel*	$435.00
☐ Change of Tradename	No Fee	☐ Reinstatement	Call Board

If reinstatement, complete the following:

Request for reinstatement is due to: ☐ lapse of license ☐ suspension or revocation of license

Has this facility engaged in the wholesale distribution of prescription drugs during the time the license was lapsed, suspended, or revoked? ☐ Yes ☐ No

The required fees must accompany the application. Fees are nonrefundable.
Make check or money order payable to "Treasurer of Virginia".

Applicant—Please provide the information requested below. (Print or Type)

Name of Business		**Federal Employer Identification Number (FEIN)**
Business Address		**Telephone Number**
City	**State** VA	**Zip Code**
Name of Responsible Party	**Email address for Responsible Party**	
Address		**Telephone Number**
City	**State**	**Zip code**
Social Security Number of Responsible Party	**Virginia Wholesale Distributor Permit Number (leave blank if new):** 0215	
Name of contact person for firm (other than Responsible Party)	**Contact person email address and telephone number**	

*** INSPECTION- For New, Remodel and Change of Location: A 14 day notice is required for scheduling an inspection.** An inspector will contact the responsible party prior to the requested inspection date to schedule. If the inspector does not contact to confirm the date, the responsible party should contact the Board at pharmbd@dhp.virginia.gov.

Requested Inspection Date:	**Expected Opening Date:**

IMPORTANT: Additional documents list found on page 4 and 5 of this application

FOR BOARD USE ONLY:

Date Processed:	**Check No:**	**Receipt No:**	**Application No:**

OWNERSHIP TYPE—check one: Corporation ☐ Partnership ☐ Individual ☐ Other ☐ _____

Name of ownership entity if different from name on application: _____

Address: _____ Phone No. _____

City: _____ State: _____ Zip Code:

State(s) of incorporation _____

List all other trade or business names used by this facility (includes "is doing business as," and "formerly known as")

Name: _____ **Name:** _____

Name: _____ **Name:** _____

Please answer the following questions for NEW or REINSTATEMENT applications:

1. Will this facility be handling any Schedule II through V controlled substances?: Yes ☐ No ☐
   If yes, a Controlled Substance Registration is also required. Application available: www.dhp.virginia.gov/pharmacy

2. Does this location operate from a private dwelling or residence? Yes ☐ No ☐

3. Does this facility location have any disciplinary actions, imposed against the entity by state or federal regulatory bodies, including any such actions against the responsible party, principals, owners, directors, or officers over the last seven years? Yes ☐ No ☐
   If yes, attach an explanation and any pertinent documentation relative to the matter including date of action and parties to the action

4. Does this applicant establish, maintain, and adhere to written policies and procedures for the proper receipt, security, storage, inventory, and distribution of prescription drugs that includes:
   - A procedure for reporting thefts or losses of prescription drugs to the board and other appropriate authorities;
   - A procedure whereby the oldest approved stock of a prescription drug is distributed first. The procedure may permit deviation from this process provided the deviation is temporary and appropriate for the distribution;
   - A procedure for handling recalls and withdrawals of prescription drugs and devices;
   - Procedures for preparing for, protecting against, and handling emergency situations that affect the security and integrity of drugs or the operations of the wholesale distributor;
   - A procedure to ensure that outdated drugs are segregated from other drugs to include the disposition of such drugs;
   - A procedure to ensure initial and ongoing training of all employees;
   - A procedure for ensuring, both initially and on an ongoing basis, that persons with access to prescription drugs have not been convicted of a violation of a drug law or any law related to wholesale distribution of prescription drugs or to third-party logistics providers; and
   - A procedure for reporting counterfeit or suspected counterfeit prescription drugs or counterfeiting or suspected counterfeiting activities to the board and other appropriate law enforcement or regulatory agencies.

   Yes ☐ No ☐

   If no, attach an explanation.

Affirmation by the responsible party:

I do solemnly affirm I:

- am the primary contact person for the board and responsible for managing the wholesale distribution operations at this location.
- have a minimum of two years of verifiable experience in a pharmacy or wholesale distributor or third-party logistics provider licensed, registered, or permitted in Virginia or another state where the person's responsibilities included managing or supervising the recordkeeping, storage, and shipment for drugs or devices.
- am employed full time in a managerial position, actively engaged in daily operations of the wholesale distributor, and present on a full-time basis at this location during normal business hours, except for time periods when absent due to illness, family illness or death, vacation, or other authorized absence.
- am not a responsible party for any other wholesale distributor location.
- am knowledgeable about all policies and procedures about the operations of the wholesale distributor and all applicable state and federal laws related to wholesale distribution of prescription drugs.

I do solemnly affirm that the information provided on this application, including responses to application questions, is true and accurate to the best of my knowledge. Furthermore, I agree to notify the board of any changes to the required information within 30 days of such change.

Signature of Responsible Party: _____

Print Name: _____

Date: _____

Attestation by the responsible party:

Has the Wholesale Distributor, responsible party, principals, owners, directors and/or officers of the facility named on this application had any past criminal convictions and violations of the state and federal laws regarding drugs or devices?

Yes ☐ No ☐

If yes, attach an explanation and any pertinent documentation related to the matter.

Does the responsible party have any criminal convictions or are they the subject of any pending criminal charges within or outside of the Commonwealth of Virginia?

Yes ☐ No ☐

If yes, attach an explanation and any pertinent documentation related to the matter.

Does the responsible party have any involvement with any business, including any investments, other than the ownership of stock in a publicly traded company or mutual fund, during the past seven years, that manufactured, administered, prescribed, distributed, or stored drugs and devices and any lawsuits, regulatory actions, or criminal convictions related to drug laws or laws concerning third-party logistics providers or wholesale distribution of prescription drugs in which such businesses were named as a party?

Yes ☐ No ☐

If yes, attach an explanation and any pertinent documentation related to the matter.

I do solemnly attest that the information provided in this section is true and accurate to the best of my knowledge.

Signature of Responsible Party: _____

Print Name: _____

Date: _____

Please attach the following additional information concerning ownership:

☐ Type of ownership and name(s) of the owner of the entity, including

A. If an individual: The name, address, social security number or control number.

B. If a partnership: The name, address, and social security number or control number of each partner, name of partnership and federal employer identification number.

C. If a corporation:
(1) The name and address of the corporation, federal employee identification number, state of incorporation, the name and address of the resident agent of the corporation;

(2) The name, address, social security number or control number, and title of each corporate officer and director;

(3) For non-publicly held corporations, the name and address of each shareholder that owns ten (10) percent or more of the outstanding stock of the corporation;

(4) The name, federal employer identification number, and state of incorporation of parent company.

D. If a sole proprietorship: Full name, address, and social security number or control number of the sole proprietor and the name and federal employer identification number of the business entity.

E. If a limited liability company, the name and address of each member, the name and address of each manager, the name of the limited liability company and federal employer identification number, the name and address of the resident agent of the limited liability company, and the name of the state in which the limited liability company was organized.

Please attach the following additional information concerning the business:

☐ A list of all states in which the entity is licensed to purchase, possess, and distribute prescription drugs and into which it ships prescription drugs.

☐ A brief description of your planned business activities for which you require this permit including examples of prescription drugs and/or devices you plan to distribute.

Please attach the following information concerning the person named as the responsible party:

☐ A passport size and quality photograph taken within 30 days of submission of the application.

☐ A resume listing employment, occupations, or offices held for the past seven years including names, addresses, and telephone numbers of the places listed and demonstrating a minimum of two years of verifiable experience in a pharmacy or wholesale distributor licensed in Virginia or another state, where the person's responsibilities included, but were not limited to, managing or supervising the recordkeeping, storage, and shipment for drugs or devices.

☐ A federal criminal history record check, either through the FBI or any third-party alternative, completed within the past 90 days.