



Virginia Department of
Health Professions
Board of Pharmacy

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APPLICATION FOR REGISTRATION AS A NONRESIDENT MANUFACTURER

Check Appropriate Box(es):

☐ New	\$1000.00	☐ Change of Responsible Party	\$125.00
☐ Change of Ownership	\$125.00	☐ Change of Location	No Fee
☐ 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 shipped into Virginia during the time the license was lapsed, suspended, or revoked? ☐ Yes ☐ No

If change of location, please include a copy of the resident state license reflecting the new address.

Application fees are not refundable. Applications are valid for one year from the date of receipt. The required fees must accompany the application. Make check payable to "Treasurer of Virginia".

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

Name of Firm		Federal Employer Identification Number (FEIN)	
Street Address	Telephone Number	Fax Number	
City	State	Zip Code	
Email Address	Current Virginia facility license, if applicable 0238-		
Name of Responsible Supervising Person:		Telephone Number of Responsible Person:	
Signature of applicant:			Date:

IMPORTANT: Please provide the following additional documentation with application:

1. A list of all prescription drugs manufactured. If manufacturing and shipping devices only and no prescription drugs, please apply for a Nonresident Warehouser Registration.
2. A brief description of your planned business activities for which you require this registration.
3. A copy of a valid, unexpired resident state license or current registration as a manufacturer or repackager with the FDA.
4. A curriculum vitae of the supervising pharmacist or other qualified person. The CV must be current to include employment at this facility.

For Finance and Board use only			0238
Date:	Applicant Number:	Receipt Number:	Check Number:
Date issued:	Reviewed by and date:		Scanned by:

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: _____			

LIST OF OWNERS/OFFICERS AND RESIDENCE ADDRESSES:	
Name: _____	Title: _____
Residence Address: _____	
Name: _____	Title: _____
Residence Address: _____	

Please answer the following question:	
1. Are the records of drugs and devices distributed and shipped into Virginia readily retrievable from other distribution records:	Yes ☐ No ☐

Attestation by the responsible person (Pharmacist, Chemist or other Qualified Person:	
I do solemnly affirm that the information provided on this application 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 Person: _____	
Print Name: _____	
Profession or Training: _____	Date: _____