



Arkansas State Board of Pharmacy
101 East Capitol, Suite 218
Little Rock, AR 72201
501-682-0190 Fax 501-682-0195
www.arkansas.gov/asbp

Application for Wholesale Distributor of Prescription (Legend) Drugs Permit

PART I: GENERAL INFORMATION

Business Name: _____

DBA or name that will appear on your permit if different from Business Name above: _____

Employer Identification Number: _____

Physical Address of Applicant:

Street: _____

City: _____

State: _____

Zip: _____

Telephone Number: _____

Fax Number: _____

Website: _____

Mailing Address (Complete this section ONLY if different from the physical address above.):

Street or PO Box: _____

City: _____

State: _____

Zip: _____

Person with whom the Board of Pharmacy may communicate regarding this application:

Name: _____

Position: _____

Telephone: _____

Email: _____

Type of Business (check all that apply):

- | | | | |
|--|--|--|------------------------------------|
| <input type="checkbox"/> Manufacturer | <input type="checkbox"/> Medical Gas Distributor | <input type="checkbox"/> Retail Pharmacy | <input type="checkbox"/> Sales |
| <input type="checkbox"/> Wholesale Distributor | <input type="checkbox"/> Jobber | <input type="checkbox"/> Hospital Pharmacy | <input type="checkbox"/> Marketing |
| <input type="checkbox"/> Repacker | <input type="checkbox"/> Warehouse | <input type="checkbox"/> Reverse Distributor | <input type="checkbox"/> Other* |

*If Other, please provide a description of your operation on a separate sheet.

Methods of Distribution (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Products shipped directly to pharmacies | <input type="checkbox"/> Products shipped directly to physicians, dentists, podiatrists |
| <input type="checkbox"/> Products shipped directly to veterinarians | <input type="checkbox"/> Products shipped to distributors, wholesalers, repackers, jobbers |
| <input type="checkbox"/> Reverse distribution | <input type="checkbox"/> Business office only-does not distribute |
| <input type="checkbox"/> Other (Please explain on a separate sheet.) | |

Classes of Drugs Distributed (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Legend drugs - human | <input type="checkbox"/> Legend drugs - veterinary |
| <input type="checkbox"/> Controlled substances - human | <input type="checkbox"/> Controlled substances - veterinary |

Controlled Substances you Plan to Ship to Arkansas (check all that apply):

- | | | | | |
|--------------------------------------|---------------------------------------|--------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Schedule II | <input type="checkbox"/> Schedule III | <input type="checkbox"/> Schedule IV | <input type="checkbox"/> Schedule V | <input type="checkbox"/> Not Applicable |
|--------------------------------------|---------------------------------------|--------------------------------------|-------------------------------------|---|

DEA Number: _____

Applied For

Not Needed

Name of DEA Registrant: _____

FOR OFFICE USE ONLY

License # _____ Date Issued: _____ Fee Submitted: _____ Check No. _____ Permit sent _____

1. Is this application made as a result of a change of ownership? If Yes, what is the name of the facility licensed by the Arkansas Board of Pharmacy? What is the license number? _____ What is the expected closing date of the sale? _____ Who was the previous owner?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Has the applicant ever been licensed in Arkansas?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Does this business conduct operations at more than one location that ships drugs into Arkansas? If Yes, are all facilities licensed in Arkansas?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
4. How long has the applicant been engaged in the wholesale distribution of drugs?	_____ years
5. Does the applicant operate a warehouse or distribution center? If Yes, has the facility been inspected?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
6. Does the applicant manufacture drug products? If Yes, is the applicant licensed by the FDA?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
7. Does the applicant use a third party logistics provider? If Yes, name and address of the provider:	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Does the applicant serve as a third party logistics provider for another company? If Yes, provide the name and address of the other company: What products do you distribute for them? (You may attach a list on a separate sheet, if necessary.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. Does the applicant distribute medical gas only?	<input type="checkbox"/> YES <input type="checkbox"/> NO
10. Does the applicant have a retail pharmacy license? If Yes, does the applicant compound drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
11. Does the applicant distribute drug samples? If Yes, please describe the samples and provide a general description of the recipients of these samples:	<input type="checkbox"/> YES <input type="checkbox"/> NO
12. Please provide a general description of the products and operations of the applicant related to the wholesale distribution of legend drugs. You may attach a separate sheet if necessary.	

PART II: APPLICANT HISTORY

Please answer each of the following questions by putting a check (✓) in the appropriate box on the right. You must answer each question with a "Yes" or "No" response as no other response is acceptable. All "Yes" answers MUST be explained in detail in a separate SIGNED and NOTARIZED affidavit. The affidavit should include all relevant dates, and identify the relevant jurisdiction and/or entity involved. Failure to disclose any of the requested information may result in the denial of your application or other appropriate action.

NOTE: If you answer "Yes" to any of the questions below and you have already submitted a detailed affidavit to the Arkansas State Board of Pharmacy explaining your response you need not submit another detailed affidavit. Please note the date of your previous submission next to the applicable question(s).

13. Is the applicant currently under investigation in any state in which it is licensed?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
14. Has the applicant ever been the subject of disciplinary action or been sanctioned by any licensing authority?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
15. Is there any disciplinary action pending against the applicant by any licensing jurisdiction, the USDA, Drug Enforcement Agency or any state drug enforcement authority?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
16. Has the applicant ever been convicted of violating any federal, state or local law related to drug samples, wholesale or retail drug distribution, or distribution of controlled substances?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
17. Has the applicant ever been convicted of violating any federal, state, or local law related to the practice of pharmacy?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
18. Have any of the applicant owners, officers, directors, or stockholders ever been convicted of a felony or crime involving the practice of pharmacy? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
19. Has any sanction or disciplinary action been taken regarding any license, permit or registration issued to the applicant, officers, directors, partners or stockholders involving drug distribution? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
20. Are there any charges pending against the applicant, officers, directors, partners or stockholders involving drug distribution? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

PART III: BUSINESS OWNERSHIP

Select the appropriate form of ownership from the choices below, and then go to the next appropriate section.

- | | |
|---|--|
| <input type="checkbox"/> Sole Proprietorship (Go to 21A)
<input type="checkbox"/> Corporation (Go to 21C)
<input type="checkbox"/> LLC (Go to 21C)
<input type="checkbox"/> Other (Please explain) | <input type="checkbox"/> General Partnership (Go to 21B)
<input type="checkbox"/> Limited Partnership (Go to 21B)
<input type="checkbox"/> LLP (Go to 21B) |
|---|--|

21A. Please provide the name, and the address of the owner of this company:

Go to Item 23.

21B. Partnership Name, if different from Applicant name listed on Page 1.

In the space provided below, please provide the names, addresses and percentage ownership of all partners/members. You may attach a list of partners/members if there is not enough space.

Go to Item 22.

21C. Corporation Name, if different from Applicant name listed on Page 1.

Check if Subchapter S Corporation

State of Incorporation:

Is this corporation publicly traded?

YES NO

Is this corporation a wholly owned subsidiary of another company or corporation?

YES NO

If Yes, what is the name of the parent company?

If No, please provide the names, addresses and percentage ownership of all of the owners of this corporation. You may use a separate sheet if you need more space.

Go to Item 22.

22. Please provide the names and titles of the officers or directors of this company.

President: _____

Vice President: _____

Secretary: _____

Treasurer: _____

Specify additional titles below:

If you need additional space for the corporate officer list, please attach the list as a separate document.

PART IV: DOCUMENTATION

23. Attach copies of the following documents to this application, or an explanation of why these documents are not included:

- (A) If the applicant is not located in Arkansas, a copy of the license/permit issued by the state in which the wholesale distributor is located. If you do not have a license in your home state, please provide a statement from your State Board of Pharmacy stating that you are not required to be licensed.
- (B) If the applicant is not located in Arkansas, a copy of the latest inspection report of the facility issued by the regulatory agency that performs such inspections in the state in which the business is located. If the facility has never been inspected, a statement from the applicant stating that the facility has never been inspected.
- (C) Copies of all federal licenses or permits. If you indicated that you will be shipping controlled substances (on page 1 of this application) you must provide a copy of your DEA permit.
- (D) A certificate of insurance for this facility issued by your insurance agent, showing your product liability insurance, or general liability insurance if you do not carry product liability insurance.
Do not send a copy of the policy – just the certificate of insurance.

PART V: APPLICATION FEE

Check **one** of the following options:

- This is a new permit application.
What is the date this application will be submitted to the Arkansas State Board of Pharmacy?
Add thirty days. What is the new date? _____
If this date falls in an even-numbered year (2008, 2010, etc.), the fee is \$300.00
If this date falls in an odd-numbered year (2009, 2011, etc.), the fee is \$450.00
- This is a change of ownership of a current license holder.
The fee for a change of ownership is \$150.00.

Please Note: The Wholesale Distributor of Prescription (Legend) Drugs Permit is a biennial permit and expires on December 31st of even-numbered years. If a permit is issued during an even-numbered year it will be up for renewal later that year.

PART VI: CERTIFICATION

Please read carefully and sign below.

I swear, or affirm, that all statements made herein and on the attached forms are true and correct. All of the provisions of Arkansas laws and regulations related to the wholesale distribution of drugs into Arkansas will be faithfully observed during the period any permit issued may be in force and effect.

This business employs adequate personnel with the education and experience necessary to safely and lawfully engage in the wholesale distribution of drugs; meets the minimum requirements for the storage and handling of prescription drugs specified in Regulation 08-00-0008; meets the minimum requirements for the establishment and maintenance of prescription drug distribution records specified in Regulation 08-00-0008; has written policies and procedures as described in Regulation 08-00-000; maintains ownership/ management/employee records as specified in Regulation 08-00-0010; complies with all applicable federal, state and local laws and regulations; and, before shipping to a recipient in Arkansas, will determine that the recipient is appropriately licensed and authorized by law to purchase and possess prescription drugs.

I understand that the Arkansas Pharmacy Lawbook contains the statutes and regulations related to the wholesale distribution of drugs into Arkansas, and is available online at the Arkansas State Board of Pharmacy website. I have read regulations 08-00-0001 through 08-00-0014 and will abide by them.

I will notify the Arkansas State Board of Pharmacy if any information contained in this application for a permit changes within thirty (30) days of the change.

By virtue of filing this application, I do solemnly swear or affirm that I am of good moral character, and that I understand the instructions and terms as set forth in this application form, that I have personally completed this form, that the information given in this application is true, correct and complete to the best of my knowledge. I authorize the Arkansas State Board of Pharmacy to review files pertaining to this application and related documents, and all law enforcement records, administrative records, and court documents to confirm the accuracy and completeness of the information provided herein. This application and signature shall act as authorization for entities in possession of applicable information to release such information to the Arkansas State Board of Pharmacy.

Signature of Owners/Representative: _____

Print the name of the Owner/Representative: _____

Position : _____

Date: _____

Checks should be made payable to: Arkansas State Board of Pharmacy.

Return the completed application and all related documents and fees to:

Arkansas State Board of Pharmacy
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Little Rock, AR 72201

Phone: 501-682-0190

Website: www.arkansas.gov/asbp