APPLICATION FOR RELOCATION OF A WHOLESALE DISTRIBUTOR

The following requirements shall apply to any Massachusetts Wholesale Distributor moving to a new address. The Wholesale Distributor shall:

1. submit to the Board a new application and payment of the appropriate fee (made payable to the “Commonwealth of Massachusetts”) in accordance with the requirements of 247 CMR 7.00 et seq. in advance of any relocation;

2. return previously issued permits with the application;

3. a Wholesale Distributor which has moved to a new address shall not begin to operate in said location until the application has been approved by the Board and until the wholesale distributor / broker has received a license from the Board to operate in addition to a controlled substances registration;

4. the application shall be accompanied by an official blueprint or certified architectural plans drawn to scale

For complete information regarding relocation regulations, please refer to 247 CMR 7.00. et seq. If additional information is necessary, please contact the Board office at (800) 414-0168.

To obtain guidance from the Drug Enforcement Administration (DEA) regarding the impact of any proposed relocation on the licensure status of a wholesale distributors existing DEA Registration, please contact the DEA at the following address:

J.F.K. Federal Building
Drug Enforcement Administration
Room E400, 15 New Sudbury Court
Boston, MA 02203-0131
Telephone: (617) 557-2200
The purpose of 247 CMR 7.00 is to implement the Federal Prescription Drug Marketing Act of 1987 ("PDMA"), U.S. Public Law 100-293, codified at 21 U.S.C. § 321 et seq. The PDMA requires that all entities engaged in the interstate and/or intrastate wholesale distribution of prescription drugs be licensed in each state where they are engaged in such activity.

247 CMR 7.00 applies to every wholesale distributor located in the Commonwealth of Massachusetts who engages in the sale, distribution, or delivery at wholesale of prescription drugs.

$900.00 licensure / application fee. Make check or money order payable to the Commonwealth of Massachusetts. This fee is non-refundable.

1. Legal Name of Business:__________________________________________________________

2. PROPOSED Relocation Address (Street Address, City, State & Zip):________________________

3. PREVIOUS location from which business is moving (Street Address, City, State & Zip):____________________

4. County________________________________________

5. Area Code & Telephone Number__________________FEIN # __________________

6. Email address for this facility:_____________________________________________________

7. Address, Telephone Number, Social Security Number, and Name of Contact Person (Designated Representative) for the facility.

   ________________________________________________________________
   ________________________________________________________________

8. All trade or business names ("DBA" names) used by same Corporation or by Licensee.

   ________________________________________________________________
9. Type of ownership or operation (i.e., sole proprietorship, partnership, corporate distribution center for multi-unit (chain) pharmacy corporation. 

If corporation, please submit articles of corporation.

10. Number of subsidiaries, related organizations, entities, or other facilities operating under the registration of the above listed business.

11. Name(s) and Social Security Number(s) of the owner(s) and/or operator(s) of the licensee. Please indicate type of ownership - Partnerships: the name of each partner and name and address of partnership; Corporations: the name and title of each corporate officer and director, the corporate names, name and address of the parent company, if any, and the State of incorporation; Sole Proprietorships: the name of the sole proprietor and the name and address of the business entity.

12. Type of Operation: (Circle all that apply)

- Full Service Wholesaler
- Repackaging
- Buying Group/Import/Export
- Distribution Center for Multiunit
- Distribution Center for Pharmacy Corporation
- Other (specify)

13. Sell Drugs to: (Circle all that apply)

- Intra-Company Sales Only
- Community Pharmacies
- Hospital Pharmacies
- Wholesalers
- Physicians or Other Practitioners
- Veterinarians
- Licensed to Prescribe
- Other (specify)

14. Type of Drugs Distributed: (Circle all that apply)

- Controlled Substances (Schedules II-V)
- Non-Federally Controlled Prescription Drugs (Schedule VI)
- Over-the-Counter Drugs
- Other (specify)

Which schedules?
15. Please check applicable controlled substance(s):

Schedule II  Schedule III  ( ) Schedule IV  ( ) Schedule V  ( ) Schedule VI
( ) Non-Narcotic  ( ) Non-Narcotic
( ) Narcotic  ( ) Narcotic

(Schedule VI includes all prescription drugs not in schedules II-V. Only schedules that are checked may be authorized)

If controlled substances are to be distributed, a controlled substance license is required from the Drug Enforcement Administration (Schedules II-V), Massachusetts Board of Registration in Pharmacy and the Department of Public Health – Drug Control Program (DCP).

16. Please submit with this application a detailed certified blueprint(s) of each facility drawn to scale.

17. Have any of the applicant(s) and/or managers-in-charge had: 1) any convictions related to the distribution of drugs (including samples); 2) any felony convictions; 3) any suspension(s) or revocation(s) or other sanctions(s) by federal, state or local governmental agency of any license or registration currently or previously held by the applicant or licensee for the manufacture or distribution of any drugs, including controlled substances? Have any applications for licensure been denied by any federal or state agency? List and explain. Attach additional sheets if necessary.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

18a. Have you and the company ever been convicted of any violation of State or Federal Law relating to the manufacture, possession, distribution, or dispensing of controlled substances?

Yes*_____  No_____

18b. Has any previous professional license or registration held by you and the company under any name or corporate name or legal entity been surrendered, revoked, suspended or denied or is such action pending?

Yes*_____  No_____

*If you answered “Yes” to Question “18a or 18b”, you must attach a certified copy of each action and or court setting forth circumstances of such action(s).

19. The applicant / licensee must notify the Board in writing of any changes in ownership or management within thirty (30) days of such change(s).

20. List state(s) in which application for licensure is being made.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

21. List state(s) in which licensure has been granted.

______________________________________________________________________________
Licensure Information for Each Facility
Provide details for each facility, using the form below. Photocopy this form and attach sheet(s) if necessary.

<table>
<thead>
<tr>
<th>Name and address of each facility: (Street Address, City, State, Zip &amp; County)</th>
<th>Area code and Telephone number of each facility</th>
<th>Full name, emergency telephone and social security</th>
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</table>
| 1. ______________________  
________________________  
________________________ | ( ) - | Full Name: |
| | | Telephone: |
| | | SSN: |
| 2. ______________________  
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________________________ | ( ) - | Full Name: |
| | | Telephone: |
| | | SSN: |
| 3. ______________________  
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________________________ | ( ) - | Full Name: |
| | | Telephone: |
| | | SSN: |
| 4. ______________________  
________________________  
________________________ | ( ) - | Full Name: |
| | | Telephone: |
| | | SSN: |
Licensure Information for Each Facility
Photocopy this form and attach additional sheets if necessary.
If the information is unavailable, please indicate N/A.

<table>
<thead>
<tr>
<th>State(s) Where Licensed</th>
<th>License Number and Expiration Date:</th>
<th>State Controlled Substances License #</th>
<th>DEA Registration Number:</th>
<th>FDA Number: (manufacturers only)</th>
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NOTE: Attach a copy of the most recent Board of Pharmacy inspection for each licensed facility
For each state where licensed.
Affidavit Pursuant to M.G.L.c.62C, s. 49, I certify under the penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

The applicant certifies that each person employed in any prescription drug wholesale distribution activity has the education, training, and experience, or any combination thereof, sufficient for that person to perform the assigned functions in such a manner as to provide assurance that the drug product quality, safety, and security will at all times be maintained as required by law.

WARNING:

In accordance with Chapter 94 M.G.L. Sec 13, the Board of Registration in Pharmacy in the case of a retail drug business or wholesale druggist, may suspend or revoke a registration to manufacture, distribute, dispense or possess a controlled substance after a hearing pursuant to the provisions of Chapter 34A and upon finding that the registrant has furnished false or fraudulent information in any application filed under the provisions of Chapter 94C.

I hereby state that I am the person authorized to sign this application for all licensure.

Signature of Owner or Corporate Officer Title Date

Social Security Number of Owner or Corporate Officer

Signature of facility (MA) Designated Representative Date

Sworn and subscribed before me this _______ day of _______ Name of Notary Public

My commission expires ______________________

NOTARY SEAL

RETAIN A COPY OF THIS APPLICATION FOR YOUR RECORDS.

ALL FEES ARE NON-REFUNDABLE AND NON-TRANSFERABLE

To be completed by the Board: Check $_________ Date _______ Number _______