The Commonwealth of Massachusetts

Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure

Board of Registration in Pharmacy
239 Causeway Street, Suite 200, 2nd Floor
Boston, MA 02114
(800) 414-0168 (office) / 617-973-0983 (fax)
http://www.mass.gov/dph/boards/ph

APPLICATION FOR LICENSURE AS A WHOLESALE DISTRIBUTOR

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. δδ 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. Full Business Address (Street Address, City, State & Zip)._____
   _____
3. County_____
4. Area Code & Telephone Number._____ FEIN #:_____
5. Address, Telephone Number, Social Security Number, and Name of Contact Person (Designated Representative) for the facility.
   _____
   _____
6. All trade or business names ("DBA" names) used by same Corporation or by Licensee.
   _____
   _____
7. E-mail address for this facility:_____
8. 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.
9. Number of subsidiaries, related organizations, entities, or other facilities operating under the registration of the above listed business._____

10. 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.

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

Full Service Wholesaler Manufacturer Repackager Buying Group/Import/Export

Distribution Center for Multiunit Distribution Center for Pharmacy Corporation

Other (specify)_____

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

Intra-Company Sales Only Community Pharmacies Hospital Pharmacies Wholesalers

Physicians or Other Practitioners Licensed to Prescribe Veterinarians

Other (specify)_____

13. 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?_____

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

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

16. 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.

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

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

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

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

Name and address of each facility: (Street Address, City, State, Zip & County)	Area code and Telephone number of each facility	Full name, emergency telephone and social security
1.	( ) -	Full Name: Telephone: SSN:
2.	( ) -	Full Name: Telephone: SSN:
3.	( ) -	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.

State(s) Where Licensed List all:	License Number and Expiration. Date No.	Date:	State Controlled Substances License #	DEA Registration Number:	FDA Number: (manufacturers only)

NOTE: Attach a copy of the most recent Board of Pharmacy inspection for each licensed facility For each state where licensed.

Affidavit (must be completed and notarized)

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

Sworn and subscribed before me this _____day 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_____