The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Board of Registration in Pharmacy
250 Washington Street, Boston, MA 02108-4619
https://www.mass.gov/orgs/board-of-registration-in-pharmacy
617-973-0960 Fax (617) 973-0980
TTY (617) 973-0895

APPLICATION FOR TRANSFER OF OWNERSHIP OF A WHOLESALE DISTRIBUTOR

Whenever there is to be a transfer of ownership of a Wholesale Distributor or if the Wholesale Distributor is to be owned by a person or entity other than the person or entity who was listed on the initial application for registration to manage and operate a Wholesale Distributor, an application for transfer of ownership shall be obtained from, and submitted to, the Board. A completed application 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 transfer of ownership;

(2) state the full name of the new owner;

(3) have attached thereto an official bill of sale or minutes of meeting; including a certified copy of asset transfer;

(4) if the new owner is a corporation:

a. have attached thereto a copy of the corporation's Articles of Organization, signed and sealed by the Secretary of State, if the corporation is incorporated in the Commonwealth;

b. have attached thereto a copy of the corporation's Foreign Corporation Certificate, signed and sealed by the Secretary of State pursuant to M.G.L. c. 181, § 4, if the corporation in incorporated in another state;

c. indicate the name and address of each officer and director of the corporation and the position held;

d. indicate the d/b/a name of the corporation; and

e. if the corporation is not publicly owned, indicate the total amount and type of stock issued to each stockholder and the names and addresses of said stockholder(s).

(5) return previously issued Board permits with the application (retain copies for your records);

For complete information regarding transfer of ownership 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 transfer of ownership 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

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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 New 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 NEW 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.

_____
_____
_____
_____

11. Name(s) of PREVIOUS owner(s) and/or operator(s) of this facility. _____
_____
_____
_____

Board of Pharmacy License Registration numbers of this facility under this PREVIOUS owner:

_____

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 Licensed to Prescribe Veterinarians

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

16. 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).

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

18. 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.

_____
_____
_____
_____

19a. 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_____

19b. 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 "19a or 19b", you must attach a certified copy of each action and or court setting forth circumstances of such action(s).

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

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

_____
_____
_____

22. 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.

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: Number:	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.

I hereby state that I am the person authorized to sign this application for all licensure; that all statements are true and correct in all respects and are made under the penalties of perjury.

_____ _____ _____
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

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.

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_____
Application Number_____