Virginia Department of Health Professions
Board of Pharmacy

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Notification of Distribution Cessation Due to Suspicious Orders

Applicant—Please provide the information requested below. (Print or Type) Use full name not initials		
Name of Wholesale Distributor	License Number	
Business Address	Area Code and Telephone Number	
City	State	Zip Code
Email Address		
Name and Title of Person Submitting Notification		
Address (if different from above)	Area Code and Telephone Number	
City	State	Zip code
Email Address		
Name of Pharmacy, Physician, or Physician Dispensing Facility No Longer Receiving Schedules II-V from Above Wholesale Distributor		
Address of Pharmacy, Physician, or Physician Dispensing Facility	Permit or License Number	
City	State	Zip code
Date Distribution was Ceased		
Type of Suspicious Orders of Controlled Substances (check all that apply): ☐ Orders of unusual size ☐ Orders deviating substantially from a normal pattern ☐ Orders of unusual frequency ☐ Other:_____		
Signature of Person Submitting Notification		Date

Any additional information may be submitted as a separate attachment.