



Virginia Department of
Health Professions
Board of Pharmacy

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Application for Registration as a Registered Agent for CBD/THC-A Oil

Application Fee: \$25.00

The required non-refundable fee must accompany the application. Make check payable to "Treasurer of Virginia".

Applicant - Please provide the information requested below. (Print Legibly or Type)

Name: Last	First	Middle/Maiden
Street Address		
City	State	Zip Code
Date of Birth ____/____/____	Social Security Number or Virginia DMV Control Number	
Email Address	Tel Number	

PLEASE ANSWER THE FOLLOWING QUESTIONS:

NOTE: A person may act as the registered agent for no more than 2 registered patients.

	YES	NO
1. Has a patient or the parent or legal guardian of a patient who is a minor or an incapacitated adult designated you to serve as the patient's registered agent?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have a current written certification from a practitioner to possess CBD or THC-A oil and a current CBD/THC-A Oil Patient Registration issued by the Board of Pharmacy?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, provide the following information for Patient Number 1:		
Patient's Full Name: _____		
Patient's Address: _____		
Patient's Date of Birth (mm/dd/yyyy): ____/____/____		
Patient's Registration Number: _____		
Name of person designating you to serve as registered agent: _____		
Person designating you is the <input type="checkbox"/> patient <input type="checkbox"/> parent/legal guardian.		
If yes, provide the following information for Patient Number 2:		
Patient's Full Name: _____		
Patient's Address: _____		
Patient's Date of Birth (mm/dd/yyyy): ____/____/____		
Patient's Registration Number: _____		
Name of person designating you to serve as registered agent: _____		
Person designating you is the <input type="checkbox"/> patient <input type="checkbox"/> parent/legal guardian.		

	YES NO
2. Do you reside in the Commonwealth of Virginia? Individuals not residing in Virginia are ineligible for registration as a registered agent.	<input type="checkbox"/> <input type="checkbox"/>
	YES NO
3. Have you had a prior conviction of a violation of any law pertaining to controlled substances? If yes, please provide a full explanation and attach any associated orders or letters from the enforcing entity. (If additional space is needed, provide as an attachment.) _____ _____ _____ _____	<input type="checkbox"/> <input type="checkbox"/>
4. Have you had a registration of a patient, parent, legal guardian or registered agent for CBD/THC-A Oil denied, suspended or revoked by the board in the previous six months?	YES NO <input type="checkbox"/> <input type="checkbox"/>
5. By entering my initials, I understand that I must submit proof of my Virginia residency and identity, and a copy of each patient's current CBD/THC-A oil written certification (DO NOT SEND THE ORIGINAL DOCUMENTATION).	INITIALS _____

Applicant's Certification: (the following must be signed and dated)

I certify by entering my signature below: I am the person applying for registration as a registered agent and meet the qualifications required by Virginia law and regulations. Further, I certify the information provided in this application has been personally provided and reviewed by me, and that statements made on the application are true and complete. I understand that providing false or misleading information, as well as omitting information, in response to information requested in this application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing license/certificate/registration.

Printed Name of Applicant	Date
Signature of Applicant	Date