Virginia Department of
Health Professions
Board of Pharmacy

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APPLICATION FOR A PERMIT AS A THIRD-PARTY LOGISTICS PROVIDER

Check Appropriate Box(es):

☐ New[1,3]	$270.00	☐ Change of Responsible Party	$50.00
☐ Change of Ownership	$50.00	☐ Change of Location/Remodel[1,3]	$150.00
☐ Change of Tradename	No Fee	☐ Reinstatement[2,3]	

Application fees are not refundable. Applications are valid for one year from the date of receipt.
The required fees must accompany the application. Make check payable to "Treasurer of Virginia".

Applicant—Please provide the information requested below. (Print or Type) Use full name not initials		
Name of Firm	**Federal Employer Identification Number (FEIN)**	
Business Address	**Area Code and Telephone Number**	
City	**State**	**Zip Code**
Name of Responsible Party		
Address	**Area Code and Telephone Number**	
City	**State**	**Zip code**
Email address	**Current Virginia facility license, if applicable** **0239-**	
Social Security Number of Responsible Party		
Name of contact person for firm	**Area Code and Telephone Number**	
Expected Opening Date	**Requested Inspection Date[1]**	
Signature of Responsible Party		**Date**

IMPORTANT: Please carefully read and complete pages 2 through 3 of this application.

[1] **A 14-day notice is required for scheduling an opening or change of location inspection.** An inspector will call prior to the requested date to confirm readiness for inspection. If the inspector does not call to confirm the date, the responsible party should call the Enforcement Division at 804-367-4691 to verify the inspection date with the inspector.

[2] **If reinstatement, complete the following:**

- **Request for reinstatement is due to ☐ lapse of license ☐ suspension or revocation of license**
- **Has this facility operated as a third-party logistics provider during the time the permit was lapsed, suspended, or revoked? ☐ Yes ☐ No**

[3] **Will this facility be handling any Schedule II through V controlled substances? ☐ Yes ☐ No**
If yes, a controlled substance registration is also required. (Application available www.dhp.virginia.gov/pharmacy)

OWNERSHIP TYPE—check one: Corporation ☐ Partnership ☐ Individual ☐ Other ☐

Name of ownership entity if different from name on application: _____

Address: _____ Phone No.

City: _____ State: _____ Zip Code: _____

State(s) of Incorporation _____

List all other trade or business names used by this facility: (includes "is doing business as," and "formerly known as")

Name: _____ **Name:** _____

Name: _____ **Name:** _____

I do solemnly affirm that the information provided on this application is true and accurate to the best of my knowledge. Furthermore, I agree to notify the board of any changes to the required information within 30 days of such change.

Signature of Responsible Party: _____

Print Name: _____

Date: _____

For affirmation by the responsible party:

I do solemnly affirm I am

- the primary contact person for the board and responsible for managing the third-party logistics provider operations at this location
- employed full time in a managerial position, actively engaged in daily operations of the third-party logistics provider, and present on a full-time basis at this location during normal business hours, except for time periods when absent due to illness, family illness or death, vacation, or other authorized absence
- not a responsible party for any other third-party logistics provider
- knowledgeable about all policies and procedures pertaining to the operations of the third-party logistics provider and all applicable state and federal laws related to third-party logistics providers of prescription drugs.

Signature of Responsible Party: _____

Print Name: _____

Date: _____

FOR BOARD USE ONLY:

Date Processed:	**Check Number:**	**Receipt Number:**	**Application Number:**	
Reviewed by:	**Date Reviewed:**	**Permit Number:** **0239**	**Date Issued:**	**Date sent to Enforcement**

Please attach the following additional general information about the business:

1. A list of all states in which the entity is licensed to provide or coordinate warehousing of or other logistics services for prescription drugs and into which it ships prescription drugs
2. A brief description of your planned business activities for which you need this license including examples of prescription items you plan to distribute.

Please attach the following additional information concerning ownership:

1. Type of ownership and name(s) of the owner of the entity, including
   A. If an individual: The name, address, social security number or control number.
   B. If a partnership: The name, address, and social security number or control number of each partner, name of partnership and federal employer identification number.
   C. If a corporation:
      (1) The name and address of the corporation, federal employee identification number, state of incorporation, the name and address of the resident agent of the corporation;
      (2) The name, address, social security number or control number, and title of each corporate officer and director;
      (3) For non-publicly held corporations, the name and address of each shareholder that owns ten (10) percent or more of the outstanding stock of the corporation;
      (4) The name, federal employer identification number, and state of incorporation of parent company.
   D. If a sole proprietorship: Full name, address, and social security number or control number of the sole proprietor and the name and federal employer identification number of the business entity.
   E. If a limited liability company, the name and address of each member, the name and address of each manager, the name of the limited liability company and federal employer identification number, the name and address of the resident agent of the limited liability company, and the name of the state in which the limited liability company was organized.
2. A list of all disciplinary actions, to include date of action and parties to the action, imposed against the entity by state or federal regulatory bodies, including any such actions against the responsible party, principals, owners, directors, or officers over the last seven years;
3. An attestation providing a complete disclosure of any past criminal convictions and violations of the state and federal laws regarding drugs or devices or an affirmation and attestation that the applicant has not been involved in, or convicted of, any criminal or prohibited acts. Such attestation shall include principals, directors, officers, the responsible party or any shareholder who owns 10% or more of outstanding stock in any non-publicly held corporation;

Please attach the following information concerning the person named as the responsible party:

1. A passport size and quality photograph taken within 30 days of submission of the application
2. A resume listing employment, occupations, or offices held for the past seven years including names, addresses, and telephone numbers of the places listed and showing a minimum of two years of verifiable experience in a pharmacy or other logistics provider licensed in Virginia or another state, where the person's responsibilities included, but were not limited to, managing or supervising the recordkeeping, storage, and shipment for drugs or devices
3. A description of any involvement by the person with any business, including any investments, other than the ownership of stock in publicly traded company or mutual fund, during the past 7 years, which manufactured, administered, prescribed, distributed, or stored drugs and devices and any lawsuits, regulatory actions, or criminal convictions related to drug laws or laws concerning distribution of prescription drugs in which such businesses were named as a party
4. A sworn statement or affirmation disclosing whether the person has a criminal conviction or is the subject of any pending criminal charges within or outside the Commonwealth
5. A criminal history record check through the Central Criminal Records Exchange. Do not use this agency's address for the "mail reply to" field. The responsible party must sign the form as the person making the request. The responsible party must complete form SP167 available at **Criminal History Record Request / Sex Offender Name Search Forms** through the Virginia State Police located at http://www.vsp.state.va.us/FormsPublications.shtm
6. Any additional information deemed by the board to be relevant to determining eligibility of a responsible party.