Virginia Department of Health Professions
Board of Pharmacy

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
(804) 367-4456 (Tel)
(804) 527-4472 (Fax)
pharmbd@dhp.virginia.gov
www.dhp.virginia.gov/pharmacy

APPLICATION FOR A PERMIT AS A NON-RESTRICTED MANUFACTURER

Check Appropriate Box(es):

☐ New[1, 3, 4, 5]	$270.00	☐ Change of Supervising Person[4]	$50.00
☐ Change of Ownership	$50.00	☐ Change of Location[1, 5]	$150.00
☐ Change of Tradename	No Fee	☐ Reinstatement[2], possibly 1, 3, 4, 5	
☐ Remodel	$150.00		

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 Employment Identification Number (FEIN)	
Street Address	Area Code and Telephone Number	
City	State	Zip Code
Virginia NR Manufacturer Permit Number (if applicable) **0208-**	Email Address for Responsible Person:	
Name of Responsible Supervising Person[4]	Area Code and Telephone Number	
Expected Opening Date	Requested Inspection Date[1]	
Signature of Applicant	Date	
IMPORTANT: Please carefully read and complete page 2 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 permit ☐ suspension or revocation of permit**
- **Has this facility operated as a restricted manufacturer during the time the permit was lapsed, suspended, or revoked? ☐ Yes ☐ No**

[3] **A list of all drugs to be manufactured must accompany this application. If the only manufacturing process is to repackage oxygen, check here. ☐**

[4] **A *curriculum vitae* of supervising pharmacist or other qualified person must be included with the application.**

[5] **Will this facility be handling any Schedule II through V controlled substances? ☐ Yes ☐ No**
If yes, a controlled substance registration is also required. (Application is 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:** _____

LIST OF OWNERS/OFFICERS AND RESIDENCE ADDRESSES:

Name: _____ Title: _____

Residence Address: _____

Name: _____ Title: _____

Residence Address: _____

Name: _____ Title: _____

Residence Address: _____

Name: _____ Title: _____

Residence Address: _____

SUPERVISING PHARMACIST, CHEMIST, OTHER QUALIFIED PERSON: (attach curriculum vitae)

Name: _____ Profession or Training: _____

If pharmacist, license number: **0202-** _____

FOR BOARD USE ONLY			
Date Processed:	**Check No:**	**Receipt No:**	**Application No:**
Date Issued:	**Permit Number:** **0208**	**Reviewed By:**	**Date Reviewed:**