



Virginia Department of
Health Professions
Board of Pharmacy

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APPLICATION FOR REGISTRATION AS A NONRESIDENT WAREHOUSER

Check Appropriate Box(es):

- | | | | |
|---|----------|---|------------|
| <input type="checkbox"/> New ^{2,3} | \$270.00 | <input type="checkbox"/> Change of Responsible Party | \$50.00 |
| <input type="checkbox"/> Change of Ownership | \$50.00 | <input type="checkbox"/> Change of Location | No Fee |
| <input type="checkbox"/> Change of Tradename ³ | No Fee | <input type="checkbox"/> Reinstatement ^{1,3} | Call Board |

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)	
Street Address	Telephone Number	Fax Number	
City	State	Zip Code	
Email Address	Current Virginia facility license, if applicable 0243-		
Name of Responsible Party:		Telephone Number of Responsible Party:	
Signature of Responsible Party:			Date:
IMPORTANT: Please carefully read and complete page 2 of this application			

¹ If reinstatement, complete the following:

- Request for reinstatement is due to: lapse of permit suspension or revocation of permit
- Has this facility shipped to the Commonwealth of Virginia during the time the permit was lapsed, suspended, or revoked? Yes No

² A list of all drugs and/or devices the facility will ship must accompany this application as well as a brief description of your planned business activities for which you require this registration.

³ Provide a legible copy of this firm’s current, unexpired, unrestricted license to ship drugs and devices in its resident state.

Please answer the following question:

1. Records of drugs distributed into Virginia are readily retrievable from other distribution records: Yes No

FOR BOARD USE ONLY:

Date Processed:	Check Number:	Receipt Number:	Application Number:
Date Issued:	Registration Number: 0243	Reviewed by:	Date Reviewed:

OWNERSHIP TYPE—check one: Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Individual <input type="checkbox"/> Other <input type="checkbox"/> _____			
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: _____	

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: _____

Print Name: _____

Title: _____ Date: _____