

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
 Madison, WI 53708-8935
 FAX #: (608) 261-7083
 Phone #: (608) 266-2112

Ship To: 1400 E. Washington Avenue
 Madison, WI 53703
 E-Mail: dsps@wisconsin.gov
 Website: <http://dsps.wi.gov>

PHARMACY EXAMINING BOARD

LICENSURE FOR OUT-OF-STATE PHARMACY

AN APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

A completed application must be on file at least 30-days prior to proposed opening date.

To license a **New Pharmacy** with the Pharmacy Examining Board, complete the Application for the Licensure of an Out-of-State Pharmacy (**Form #2737**), making sure to provide all information requested.

To re-license a pharmacy because of a **Change of Ownership** or **Location Change**, complete the Application for the Licensure of an Out-of-State Pharmacy" (**Form #2737**), making sure to provide all information requested.

- No Pharmacy that is in another state may ship, mail, or otherwise deliver a prescribed drug or device to persons in Wisconsin unless the Pharmacy is licensed in Wisconsin (Wis. State Stat. § 450.065).
- An Out-of-State Pharmacy that applies for a license is not required to comply with Wisconsin law relating to the professional service area of a Pharmacy or the minimum equipment requirements for a pharmacy.
- A Pharmacist employed in an Out-of-State Pharmacy is not required to be licensed in Wisconsin.
- A licensed Out-of-State Pharmacy is not required to be under the control of a Managing Pharmacist licensed in Wisconsin.
- A licensed Out-of-State Pharmacy shall provide a telephone number that allows a person in Wisconsin to contact the Pharmacy during the Pharmacy's regular hours of business and that is available for use by a person in Wisconsin for not less than 40 hours per week.
- The label of all prescription drug containers shipped, mailed, or otherwise delivered to a person in Wisconsin must bear the telephone number of the Out-of-State Pharmacy.

Wis. State Stat. § 450.06 (3), requires that a new pharmacy license be obtained following a change of ownership. The following chart sets forth when a change of ownership is deemed to have occurred or not occurred. Following the issuance of a new license, that new licensee must also renew that new license at the next required renewal date, regardless of when that new license was issued.

OWNER	TRANSACTION	CHANGE OF OWNERSHIP?
Individual	Sells pharmacy to another	Yes
Individual	"Incorporates" him or herself and there are no other shareholders.	No
Individual	Incorporates and adds shareholders other than self, or goes into partnership with other(s).	Yes
Partnership	Sells pharmacy to another	Yes
Partnership	Members of partnership change <u>and</u> dissolves; e.g., individual(s) leaves.	Yes
Partnership	Members of partnership change, but partners vote not to dissolve unanimately or by partnership agreement.	No
Partnership	Partnership decides to incorporate itself	No
Corporation	Change in shareholders (including sale of all stock)	No
Corporation	Sells all assets (as opposed to stock)	Yes
Corporation	Becomes a subsidiary or division of another corporation.	No

ⁱ Wis. Stat. § 450.06(3), provides in relevant part as follows:

No pharmacy may be opened or kept open for practice following a change of ownership . . . unless the pharmacy is licensed for the new owner . . . notwithstanding any remaining period of validity under the pharmacy's license under the previous owner . . .

ⁱ Limited Liability Companies created under Wis. Stat. § 183, are the same as Corporations for change of ownership.

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Under Wisconsin law, the Department must deny your application if you are liable for delinquent State Taxes or Child Support (Wis. Stats. § 440.12).

PLEASE TYPE OR PRINT IN INK <input type="checkbox"/> Your name and address are available to the public. Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14).													
<input type="checkbox"/> New Pharmacy Application (never held a WI license)	Current WI License #: (list current WI license number and choose option below) <input style="width:100px;" type="text"/> <input type="checkbox"/> Change of Ownership Pharmacy Application <input type="checkbox"/> Change of Location Pharmacy Application												
FEIN # <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/> - <input style="width:20px;" type="text"/>	Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.												
Applicant Name (individual, partnership, association, or corporation) <input style="width:100%;" type="text"/>													
Pharmacy DBA Name (name or title under which business is operated, this must be the name on the pharmacy label) <input style="width:100%;" type="text"/>													
Pharmacy Address (street, city, state, zip) <input style="width:100%;" type="text"/>	Telephone Number <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/> - <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/> - <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/>												
Mailing Address (if different) <input style="width:100%;" type="text"/>	Fax Number <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/> - <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/> - <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/>												
Pharmacy Email Address <input style="width:100%;" type="text"/>													
Name of Owner or Names and Titles of all Partners or Corporate Officers and Percentage of Ownership (attach additional sheets if necessary)													
<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:40%;">Name</th> <th style="width:5%;">%</th> <th style="width:40%;">Name</th> <th style="width:5%;">%</th> </tr> </thead> <tbody> <tr> <td><input style="width:100%;" type="text"/></td> <td><input style="width:20px;" type="text"/></td> <td><input style="width:100%;" type="text"/></td> <td><input style="width:20px;" type="text"/></td> </tr> <tr> <td><input style="width:100%;" type="text"/></td> <td><input style="width:20px;" type="text"/></td> <td><input style="width:100%;" type="text"/></td> <td><input style="width:20px;" type="text"/></td> </tr> </tbody> </table>	Name	%	Name	%	<input style="width:100%;" type="text"/>	<input style="width:20px;" type="text"/>							
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Enclose copy of current license, permit, or registration certificate issued by the regulatory authority of the home state or territory OR a letter from such authority certifying the Pharmacy's compliance with the pharmacy and controlled substances laws of the home state.													
Enclosed (check one): <input type="checkbox"/> License <input type="checkbox"/> Compliance Letter													

APPLICATION FEES: Please check applicable box. Make check payable to DSPS and attach to this application.

- Initial Credential Fee**
 \$ 75.00 Initial Credential Fee
 \$ 75.00 Total Fee Attached

For Receiving Use Only (43)

Wisconsin Department of Safety and Professional Services

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

Application (Form #2737) and appropriate fee

Date of Purchase of Pharmacy
(Date of Sale to be signed, for a Change-in-Ownership only.)

Proposed Opening Date
(Required for a Change-in-Ownership or a Change-in-Location.)

Proposed Close Date of Current License #
(Required for a Change-in-Ownership or a Change-in-Location.)

Managing Pharmacist

State License #

Pharmacy Hours Daily (open - close)

CONTINUING EDUCATION AND RENEWAL REQUIREMENTS: Please view the Department website at <http://dsps.wi.gov> and select the "Professional Credential Renewal Information".

CONTINUING DUTY OF DISCLOSURE:

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that Credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

This is to certify that I have read and approved the foregoing and the statements are true and correct to the best of my knowledge and belief; and that I know the laws relating to the practice of pharmacy in Wisconsin.

By signing below, I am signifying that I have read the above statements (Continuing Duty of Disclosure and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

Owner Signature (if a sole proprietorship)

Date

Printed Name

Managing Pharmacist (if not a sole proprietorship)

Date

Printed Name

State License #

Date