APPLICATION INSTRUCTIONS: (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, please complete steps 1 through 5 below:

1. Complete the Application for the Licensure of a Pharmacy (Form #609) and fee, making sure to provide all information requested on both sides of the form.

2. Prepare and submit one set of original floor plans, scaled to size, with a description of the various areas designated. Please indicate location of sink and refrigerator. (For specific floor plan requirements, please refer to Wis. Admin. Code § Phar 6 Relating to the Practice of Pharmacy.)

3. Complete and submit self-inspection (Form #2550) with the expected dates of compliance per Wis. Admin. Code§ Phar 6.

4. Mail the above items to the Pharmacy Examining Board at the address above, at least 30-days prior to the proposed opening date. Requirements and procedures for applying for a Pharmacy license are specified in Wis. State Stats. § 450.06. A Pharmacy may not operate unless a Pharmacy license has been granted. Board action shall be taken within 6 business days of receipt of a completed Pharmacy application, as provided in Wis. Admin. Code. § Phar 4.03.

5. Contact the Federal Drug Enforcement Administration (DEA) for registration forms at www.deadiversion.usdoj.gov, (312) 353-1236, DEA, 230 South Dearborn Street, Ste. 1200, Chicago, IL 60604.

6. A Closing Affidavit must be completed and notarized by the former owner and forwarded to the Pharmacy Board Office within 10-days of actual closure date.

PROCEDURE FOR REPORTING THEFT OR LOSS OF CONTROLLED SUBSTANCES:

Phar 8.02(3) (f) Records: In any instance, that a pharmacy, practitioner, or other DEA registrant authorized to possess controlled substances is required to file with the DEA a report of theft or loss of controlled substances, the pharmacy, practitioner or other DEA registrant shall also send a copy to the board within 2 weeks of filing with the DEA.

Any pharmacy, practitioner, or other drug enforcement administration registrant is responsible for reporting the theft or significant loss of controlled substances to:

1. U.S. Department of Justice, DEA Kluczynski Building, Ste. 1200, 230 S. Dearborn Street, Chicago, IL 60604 (312-353-1236, or 1-800-478-7642 toll free 24 hours)

2. Wisconsin Pharmacy Examining Board, P.O. Box 8935, Madison, WI 53708-8935, (608-266-2112)

Report the theft or loss on DEA Form #106, (Report of Theft or Loss of Controlled Substances), obtainable from DEA at www.deadiversion.usdoj.gov.

All thefts and any significant losses must be reported to the DEA immediately upon discovery of the theft or loss. Notification must be accomplished by completing and filing a DEA Form #106, (Report of Theft or Loss of Controlled Substances). The form may be found on the Internet at www.DEAdiversion.usdoj.gov or may be obtained from your local DEA office. If the circumstances regarding the theft or loss need clarification before the form can be completed, the registrant can make an initial report via telephone or some other means and file the completed form as soon as the circumstances are known.

CHANGE OF LOCATION OR CHANGE OF OWNERSHIP:

To re-license a Pharmacy because of a change of ownership or change of location, complete the “Application for the Licensure of an In-State Pharmacy” (Form #609), making sure to provide all information requested.

Wis. State Stats. § 450.06 (3), requires that a new Pharmacy license be obtained following a change of ownership. The chart on the following page 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.

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<table>
<thead>
<tr>
<th>OWNER</th>
<th>TRANSACTION</th>
<th>CHANGE OF OWNERSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Sells Pharmacy to another</td>
<td>YES</td>
</tr>
<tr>
<td>Individual</td>
<td>“Incorporates” him or herself and there are no other shareholders</td>
<td>NO</td>
</tr>
<tr>
<td>Individual</td>
<td>Incorporates and adds shareholders other than self, or goes into partnership with other(s)</td>
<td>YES</td>
</tr>
<tr>
<td>Partnership</td>
<td>Sells pharmacy to another</td>
<td>YES</td>
</tr>
<tr>
<td>Partnership</td>
<td>Members of partnership change and dissolves; e.g., individual(s) leaves</td>
<td>YES</td>
</tr>
<tr>
<td>Partnership</td>
<td>Members of partnership change, but partners vote not to dissolve unanimously or by partnership agreement</td>
<td>NO</td>
</tr>
<tr>
<td>Partnership</td>
<td>Partnership decides to incorporate itself</td>
<td>NO</td>
</tr>
<tr>
<td>Corporation</td>
<td>Change in shareholders (including sale of all stock)</td>
<td>NO</td>
</tr>
<tr>
<td>Corporation</td>
<td>Sells all assets (as opposed to stock)</td>
<td>YES</td>
</tr>
<tr>
<td>Corporation</td>
<td>Becomes a subsidiary or division of another corporation</td>
<td>NO</td>
</tr>
</tbody>
</table>

Wis. State Stats. § 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.

Limited Liability Companies created under Wis. State Stats. § 183 are the same as Corporations for change of ownership.
### Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935  
Madison, WI 53708-8935

Ship To: 4822 Madison Yards Way  
Madison, WI 53705

FAX #: (608) 251-3036  
Phone #: (608) 266-2112

E-Mail: dsps@wisconsin.gov  
Website: http://dsps.wi.gov

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**PHARMACY EXAMINING BOARD**

**IN-STATE PHARMACY LICENSE APPLICATION**

<table>
<thead>
<tr>
<th>PLEASE TYPE OR PRINT IN INK</th>
<th>☐ 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).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Pharmacy: ☐ Community ☐ Institutional</td>
<td>Application Type: ☐ Change of Ownership for an existing Pharmacy ☐ New Pharmacy</td>
</tr>
</tbody>
</table>

**Pharmacy FEIN#:**

| | | | | | | | |

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.

**Existing WI Pharmacy License #:**

| | | | | | - | 4 - 2 |

** Applicant Name: (individual, partnership, association, or corporation)**

**Pharmacy DBA Name: (name or title under which business is operated, this must be the name on the pharmacy label)**

**Business Telephone Number:**

| | | | | | | |

**Business Fax Number:**

| | | | | | | |

**Pharmacy Physical Address:** (number, street, city, state, zip)

**Pharmacy Mailing Address:** (number, street, city, state, zip)

**Name of Owner, or Names and Titles of All Partners, or Corporate Officers and Percentage of Ownership.** (Attach additional sheets if necessary.)

| Name | % | Name | % |

**Email Address:**

**Proposed Opening Date:**

| | | | | | |

**Barrier Per Wis. Admin. Code Phar 6.04 3(1)**

☐ Yes ☐ No

**Date of Purchase of Pharmacy:** (date of sale to be signed, change of ownership only)

| | | | | | |

**Proposed Close Date of Current License #** (required for a change in ownership or change in location)

| | | | | | |

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

☐ $74.00 Initial Credential Fee

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### Wisconsin Department of Safety and Professional Services

**Pharmacy Hours:**

<table>
<thead>
<tr>
<th>Daily (open – close)</th>
<th>Saturday Hours (open – close)</th>
<th>Sunday Hours (open – close)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sundry Hours:**

<table>
<thead>
<tr>
<th>Daily (open – close)</th>
<th>Saturday Hours (open – close)</th>
<th>Sunday Hours (open – close)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ANSWER THE FOLLOWING QUESTIONS:** (attach additional sheet(s) if necessary)

1. Has the applicant previously (or currently) been licensed to operate a Pharmacy in Wisconsin? **If yes, give license number(s):**
   - [ ] Yes  [ ] No

2. Is the applicant registered or licensed in any other profession(s)? **If yes, state what profession(s) and in what state(s):**
   - [ ] Yes  [ ] No

3. Has the Managing Pharmacist listed on this application ever been convicted of a felony or misdemeanor, or have pending charges against them? **If yes, submit Convictions and Pending Charges (Form #2252).**
   - [ ] Yes  [ ] No

4. Has the Managing Pharmacist listed on this application ever had a Pharmacist license limited, suspended, revoked or reprimanded in this or any other state? **If yes, please explain.**
   - [ ] Yes  [ ] No

5. Has any owner, partner, shareholder or corporate officer, currently possessing more than a twenty percent (20%) ownership interest in the applicant Pharmacy ever had a Pharmacist license limited, suspended, revoked, or reprimanded in this or any other state? **If yes, submit Convictions and Pending Charges (Form #2252).**
   - [ ] Yes  [ ] No

6. Has any owner, partner, shareholder or corporate officer, currently possessing more than a twenty percent (20%) ownership interest in the applicant Pharmacy ever been convicted of a misdemeanor or a felony? **If yes, submit Convictions and Pending Charges (Form #2252).**
   - [ ] Yes  [ ] No

7. Does any owner, partner, shareholder, or corporate officer, currently possessing more than a twenty percent (20%) ownership interest in the applicant Pharmacy have a felony or misdemeanor charges pending against them? **If yes, submit Convictions and Pending Charges (Form #2252).**
   - [ ] Yes  [ ] No

**INSPECTION:** Please complete a self-inspection report (Form #2550) and submit to the Pharmacy Board Office. Within one year from date of licensure, a representative of the Board will perform an audit of the Pharmacy.

**We will be ready for inspection any time after:**

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/ / /
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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; that I will comply with the provisions of the Wisconsin Statutes and the Rules of the Pharmacy Examining Board and that I understand I am to be responsible for any violation(s) occurring during my tenure.

**Managing Pharmacist Signature**

__________________________

**Date**

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/ / /
```

**Printed Name of Managing Pharmacist**

__________________________

**Managing Pharmacist WI License #**

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- 40
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Committed to Equal Opportunity in Employment and Licensing
Wisconsin Department of Safety and Professional Services

AFFIDAVIT OF APPLICANT:
I/We declare that the foregoing statements are true and correct to the best of my/our knowledge and belief; the license applied for is to cover only the Pharmacy indicated above and at the location specified; and that I/we will comply with the provisions of the Wisconsin Statutes and the Rules of the Pharmacy Examining Board.

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.

By signing below, I amsignifying 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.

Applicant Signature ___________________________ Date ___/___/_____

Printed Name ___________________________

Printed Title ___________________________

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