

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
 Madison, WI 53708-8935
FAX #: (608) 251-3036
Phone #: (608) 266-2112

Ship To: 4822 Madison Yards Way
 Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: <http://dsps.wi.gov>

PHARMACY EXAMINING BOARD

APPLICATION FOR IN-STATE DRUG OR DEVICE MANUFACTURER LICENSE

Under Wisconsin law, the Department must deny your application if you are liable for delinquent State Taxes or Child Support (Wis. Stat. §§ 440.12 and 440.13).

PLEASE TYPE OR PRINT IN INK Your name, address, telephone number, and email address are available to the public. Check box to withhold address, telephone number, and email address from lists of 10 or more credential holders (Wis. Stat. § 440.14).

| | |
|--|---|
| CURRENT WI LICENSE NUMBER: <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/> - 44 | You must choose one of the following options below: <input type="checkbox"/> New Facility <input type="checkbox"/> Change of Location <input type="checkbox"/> Change of Ownership |
|--|---|

APPLICANT check one box and list name below: Individual Partnership Association Corporation Other: _____

DOING BUSINESS AS (DBA) NAME: (This is the name or title under which the business is operated. This name must be on the pharmacy label.)
 Note: This is the name that will appear on the license once issued.

| | |
|--|--|
| BUSINESS PHONE NUMBER: <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> - <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> | BUSINESS FAX NUMBER: <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> - <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> |
|--|--|

FACILITY ADDRESS: (number, street, city, zip code)

MAILING ADDRESS: (number, street, city, zip code)

EMAIL ADDRESS:

FEIN NUMBER:

.

NAME OF OWNER OR NAMES AND TITLES OF ALL PARTNERS OR CORPORATE OFFICERS AND PERCENTAGE OF OWNERSHIP (Attach additional sheet(s) if necessary.):

| NAME | % | NAME | % |
|---|---|---|---|
| <input style="width: 90%; height: 20px; border: 1px solid black;" type="text"/> | <input style="width: 15%; height: 20px; border: 1px solid black;" type="text"/> | <input style="width: 90%; height: 20px; border: 1px solid black;" type="text"/> | <input style="width: 15%; height: 20px; border: 1px solid black;" type="text"/> |
| <input style="width: 90%; height: 20px; border: 1px solid black;" type="text"/> | <input style="width: 15%; height: 20px; border: 1px solid black;" type="text"/> | <input style="width: 90%; height: 20px; border: 1px solid black;" type="text"/> | <input style="width: 15%; height: 20px; border: 1px solid black;" type="text"/> |

Provide name(s) of person(s) personally supervising scientific or technical operations in the facility along with a detail of the scientific and technical training, including colleges attended and scholastic degrees. (Attach an extra sheet if necessary.)

| | |
|---|--|
| <p>APPLICATION FEES: Make check payable to DSPS for the total DSPS fee and attach to this application.</p> <p><input type="checkbox"/> \$ 74.00 Initial Credential Fee</p> | <p>For Receipting Use Only (44)</p> |
|---|--|

Wisconsin Department of Safety and Professional Services

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

- Application (**Form #611**) and fee,
- Drug or Device Manufacturer Self-Inspection Report (**Form #2599**).
- Convictions and Pending Charges (**Form #2252**), if applicable, and

ANSWER THE FOLLOWING QUESTIONS (Attach additional sheet(s) if necessary.):

| | | | | | | | | | | | | | | | | | |
|---|--|--|------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. Indicate your Food and Drug Administration registration number and expiration date: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; border-bottom: 1px solid black;"><u>Agency</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Registration Number</u></td> <td style="width: 50%; border-bottom: 1px solid black;"><u>Expiration Date</u></td> </tr> <tr> <td style="border-bottom: 1px solid black; height: 20px;"></td> <td style="border-bottom: 1px solid black; height: 20px;"></td> <td style="border-bottom: 1px solid black; height: 20px; text-align: center;"> <table style="margin: 0 auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> </td> </tr> </table> | <u>Agency</u> | <u>Registration Number</u> | <u>Expiration Date</u> | | | <table style="margin: 0 auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> | | | | | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <u>Agency</u> | <u>Registration Number</u> | <u>Expiration Date</u> | | | | | | | | | | | | | | | |
| | | <table style="margin: 0 auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 2. If applicable, indicate your Drug Enforcement Administration registration number and expiration date. <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; border-bottom: 1px solid black;"><u>Agency</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Registration Number</u></td> <td style="width: 50%; border-bottom: 1px solid black;"><u>Expiration Date</u></td> </tr> <tr> <td style="border-bottom: 1px solid black; height: 20px;"></td> <td style="border-bottom: 1px solid black; height: 20px;"></td> <td style="border-bottom: 1px solid black; height: 20px; text-align: center;"> <table style="margin: 0 auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> </td> </tr> </table> | <u>Agency</u> | <u>Registration Number</u> | <u>Expiration Date</u> | | | <table style="margin: 0 auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> | | | | | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <u>Agency</u> | <u>Registration Number</u> | <u>Expiration Date</u> | | | | | | | | | | | | | | | |
| | | <table style="margin: 0 auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 3. Has the applicant previously been licensed by the Wisconsin Pharmacy Examining Board? If yes, give name, license number and location: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div> | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | |
| 4. Have any of the principals ever been charged with a felony or misdemeanor? If yes, submit Convictions and Pending Charges (Form #2252). | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | |
| 5. Have any of the principals had their Pharmacists, Pharmacy, Manufacturer, or Distributor license suspended, revoked, or reprimanded in this or any other state? If yes, please explain. | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | |
| 6. Do any of the principals have a Pharmacy, Pharmacist, Manufacturer, or Distributor license now subject to disciplinary proceedings in this or any other state? If yes, please explain. | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | |
| 7. Have any of the principals or applicant conducted a similar business in any other state? If yes, provide licensing state(s) and license number(s): <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div> | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | |

IF THE TYPE OF BUSINESS IS A LLC OR OTHER ENTITY, LIST THE FULL NAME OF EACH MEMBER AND THE NAME OF THE BUSINESS ENTITY (Attach additional sheet(s) if necessary.):

LIST PRESCRIPTION OR NON-PRESCRIPTION DRUGS AND CONTROLLED SUBSTANCES MANUFACTURED OR REPACKAGED WITH MANUFACTURERS TRADE NAME AND GENERIC NAME BELOW (Attach an extra sheet if necessary.):

| | |
|-------------------|---------------------|
| Trade Name | Generic Name |
| | |
| | |

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 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.

Applicant Signature: Date: / /