

**State of Florida**  
**Department of Business and Professional Regulation**  
**Division of Drugs, Devices, and Cosmetics**

**Application for Limited Prescription Drug Veterinary Wholesale Distributor**  
**Form No.: DBPR-DDC-219**

**APPLICATION CHECKLIST – IMPORTANT – Submit all items on the checklist below with your application to ensure faster processing.**

APPLICATION	APPLICATION REQUIREMENTS
<p><b>Application for Permit as a Limited Veterinary Prescription Drug Wholesale Distributor</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Establishments located in the state of Florida, enclose \$1150.00 fee, which includes \$1,000.00 application fee and \$150.00 initial application/on-site inspection fee.</li> <li><input type="checkbox"/> Establishments located outside the State of Florida, enclose \$1,000.00 fee.</li> <li><input type="checkbox"/> \$20,000 bond.</li> <li><input type="checkbox"/> Make cashier's check or money order payable to the Florida Department of Business and Professional Regulation.</li> <li><input type="checkbox"/> If the applicant answered "Yes" to any question in Section IV, enclose a detailed explanation along with any relevant documentation.</li> <li><input type="checkbox"/> Sign and date the Affidavit section of the application.</li> </ul>
	<p>Submit the completed application with enclosures to:            Department of Business and Professional Regulation            1940 North Monroe Street            Tallahassee, FL 32399</p>

**State of Florida  
Department of Business and Professional Regulation  
Division of Drugs, Devices, and Cosmetics**

**Application for Limited Prescription Veterinary Drug Wholesale Distributor  
Form No.: DBPR-DDC-219**

If you have any questions or need assistance in completing this application, please contact the Department of Business and Professional Regulation, Division of Drugs, Devices and Cosmetics, at **850.717.1800**. ***For additional information see the instructions at the beginning of this application.***

**Section I- Application Type**

CHECK ONE OF THE APPLICATION TYPES
<input type="checkbox"/> New Application [3344/1020] <input type="checkbox"/> New Application due to change in ownership. If checked, provide legal documentation for the change of ownership (i.e. Bill of Sale, stock transfer, merger). [3344/1020] Current Permit Number _____

**Section II – Applicant Information**

APPLICANT INFORMATION		
Federal Tax Identification Number:		
FULL LEGAL NAME		
Applicant's Full Legal Name:		
FICTITIOUS, TRADE OR BUSINESS NAME (only if applicant intends to operate under the permit under a name different from full legal name)		
Full Fictitious, Trade or Business Name (sometimes "d/b/a" or "dba"):  _____		
<u>Note:</u> This name will appear on the permit and must be used on the applicant's operational documents for permitting activities.		
If the applicant intends to operate under a fictitious, trade or business name, provide the corresponding registration number for the Florida Secretary of State, Division of Corporations: _____		
APPLICANT'S MAILING ADDRESS		
Street Address or P.O. Box:		
City:	State:	Zip Code (+4 optional):
PHYSICAL ADDRESS OF ESTABLISHMENT TO BE PERMITTED		
Street Address:		
City:	State:	Zip Code (+4 optional):
County (if Florida address):	Country:	
E-Mail Address:	Phone Number:	Fax Number:

APPLICATION CONTACT			
Whom should the department contact with questions regarding this application?			
Last/Surname	First	Middle	Suffix
Address:			
City:		State:	Zip Code (+4 optional):
Telephone Number		Fax Number:	
E-Mail Address:			
EMERGENCY CONTACT -RESIDENT INFORMATION			
Last/Surname	First	Middle	Suffix
Position/Title:			
Residence Street Address (must be different than establishment physical address)			
City:		State:	Zip Code (+4 optional):
Residence Phone Number:		E-Mail Address:	
OPERATING HOURS			
List Operating Hours – minimum 10 total per week (M-F) between 8:00 a.m. and 5:00 p.m. Eastern Standard Time, and at least 2 consecutive hours on at least 1 day:			
Mon ____:____ am/pm to ____:____ am/pm	Fri ____:____ am/pm to ____:____ am/pm		
Tue ____:____ am/pm to ____:____ am/pm	Sat ____:____ am/pm to ____:____ am/pm		
Wed ____:____ am/pm to ____:____ am/pm	Sun ____:____ am/pm to ____:____ am/pm		
Thu ____:____ am/pm to ____:____ am/pm			

### Section III – Ownership Information

TYPE OF OWNERSHIP		
<input type="checkbox"/> Publicly Held Corporation	<input type="checkbox"/> Closely Held Corporation	<input type="checkbox"/> Limited Liability Company
<input type="checkbox"/> Charitable Organization—501(c)(3)	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Government
<input type="checkbox"/> Partnership – General	<input type="checkbox"/> Professional Corporation or Association	<input type="checkbox"/> Professional Limited Liability Company
<input type="checkbox"/> Partnership – Other, Including Limited Liability Partnership and Limited Partnership	<input type="checkbox"/> Other: _____	
List the state of incorporation or state of organization (except Partnership – General or Sole Proprietorship). Business entities organized under non-U.S. laws list the country of organization.		
<b>State or Country:</b>		

List name and address of the applicant's registered agent for service of process in Florida (except Sole Proprietorship or Partnership – General).			
Name:			
Address:			
City:		State:	Zipcode (+4 Optional):
List the name, position/title, date of birth and percentage of ownership, if applicable, for the applicant's owners, partners, members, managers, and corporate officers/directors.			
Name	Position/Title	Date of Birth	% of Ownership
List all trade or business names used by the applicant. Use additional sheet(s) if necessary.			
Is the applicant a subsidiary of another company? (If yes, provide a listing of all parent companies with percentages of ownership, using additional sheet(s) if necessary. <b>Note:</b> A permit issued pursuant to this application is only valid for the applicant, and the applicant's name and address.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
Parent Company Name		% of Ownership	

#### Section IV – Background Questions

BACKGROUND QUESTIONS			
1.	<input type="checkbox"/> Yes If yes, explain in detail in Section V	<input type="checkbox"/> No	Has the applicant or any "affiliated party" (defined below) been found guilty (regardless of adjudication) or pled nolo contendere in any jurisdiction of a violation of law that directly relates to a drug, device or cosmetic?
2.	<input type="checkbox"/> Yes If yes, explain in detail in Section V	<input type="checkbox"/> No	Has the applicant or any affiliated party been fined or disciplined by a regulatory agency in any state (including Florida) for any offense that would constitute a violation of Chapter 499, F.S.?
3.	<input type="checkbox"/> Yes If yes, explain in detail in Section V	<input type="checkbox"/> No	Has the applicant or any affiliated party been convicted (regardless of adjudication) of any felony under a federal, state (including Florida), or local law?
4.	<input type="checkbox"/> Yes If yes, explain in detail in Section V	<input type="checkbox"/> No	Has the applicant or any affiliated party been denied a permit or license in any state (including Florida) related to an activity regulated under Chapters 456, 465, 499, 893, F.S.?

5	<input type="checkbox"/> Yes If yes, explain in detail in Section V	<input type="checkbox"/> No	Has the applicant or any affiliated party had any current or previous permit or license suspended or revoked which was issued by a federal, state or local governmental agency relating to the manufacture or distribution of drugs, devices, or cosmetics?
6	<input type="checkbox"/> Yes If yes, explain in detail in Section V	<input type="checkbox"/> No	Has the applicant or any affiliated party ever held a permit issued under Chapter 499, F.S. in a different name than the applicant's name? If yes, provide the names in which each permit was issued and at what address?

The term "affiliated party" includes all of the following that may apply: the applicant's (i) directors, officers, trustees, partners, or committee members; (ii) any person who manages, controls or oversees the applicant's operations (does not have to be an employee), including the establishment manager and the next four (4) highest ranking employees responsible for prescription drug wholesale operations; and (iii) the five (5) individuals (natural persons) who own at least 5% of the applicant's stock ownership interest.

If you answered "YES" to any questions in Section IV, provide detailed explanations in Section V, including requirements for submitting supporting legal documents. If needed, explain on separate sheet(s).

**Section V – Explanation(s) for "Yes" response(s) to background question(s)**

EXPLANATION	

**Section VI – Other Permits or Licenses**

PERMITS OR LICENSES			
1.	Are there any other permits or licenses issued by any agency of the State of Florida that authorize the purchase or possession of prescription drugs at the applicant's establishment or address? (If yes, provide the name in which the permit is issued, the permit type, & permit number in the spaces provided below.)		<input type="checkbox"/> Yes <input type="checkbox"/> No
1.a	Permit/License Name	Permit/License Type	Permit/License Number

2.	Does the location for which you are applying ship prescription drugs (subject to, defined by, or described by s. 503(b) of the Federal Food, Drug, & Cosmetic Act) in or into Florida? (If no, provide the name(s) and address(es) from which the drugs are shipped into Florida.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2a.	Name	Physical Address
		Florida Permit or License No:

**Section VII – Distribution Activity**

<b>DISTRIBUTION ACTIVITIES</b>		
Generally identify the applicant's intended customers, the persons and entities that will purchase or receive products from the applicant after permit issuance.		
<input type="checkbox"/> Manufacturers	<input type="checkbox"/> Wholesalers	<input type="checkbox"/> Pharmacies
<input type="checkbox"/> Hospitals	<input type="checkbox"/> Practitioners	<input type="checkbox"/> Clinics
<input type="checkbox"/> Veterinarians		
<input type="checkbox"/> Other (explain) _____		
Identify the types of drugs the applicant will sell or distribute in or into Florida? (Check all that apply in the space below).		
<input type="checkbox"/> Veterinary Prescription Drugs (approved for animal use only)		
<input type="checkbox"/> Human Prescription Drugs		
<input type="checkbox"/> Solid Dose		
<input type="checkbox"/> Liquids (Oral)		
<input type="checkbox"/> Injectables		
<input type="checkbox"/> Topical		
<input type="checkbox"/> Dental		
<input type="checkbox"/> Ophthalmic		
<input type="checkbox"/> Compressed Medical Gases		
Controlled Substances: Provide your DEA Number: _____		
Check Schedules: <input type="checkbox"/> Sch II <input type="checkbox"/> Sch III <input type="checkbox"/> Sch IV <input type="checkbox"/> Sch V		
1.	Do you understand that only 30% of your total annual prescription drug sales can be prescription drugs (subject to, defined by, or described by s. 503(b) of the Federal Food, Drug, & Cosmetic Act)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Does the applicant, at any establishment operated by the applicant, distribute prescription drugs (subject to, defined by, or described by s. 503(b) of the Federal Food, Drug & Cosmetic Act) or veterinary prescription drugs to any person other than persons:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	a. Licensed as veterinarians practicing on a full-time basis;	

	<p>b. Regularly and lawfully engaged in instruction in veterinary medicine;</p> <p>c. Regularly and lawfully engaged in law enforcement activities;</p> <p>d. For use in research not involving clinical use; or</p> <p>e. For use in chemical analysis or physical testing or for purposes of instruction in law enforcement activities, research, or testing.</p>	
3.	<p>For all prescription drug sales by the applicant (includes all sales by the entity identified by the Federal Employer Identification Number provided in this application), for the most recent calendar year ending December 31<sup>st</sup>, provide the percentage of those total sales that WERE prescription drugs (subject to, defined by, or described by s. 503(b) of the Federal Food, Drug &amp; Cosmetic Act).</p> <p>Annual Sales % from January 1, through December 31: _____</p>	Percentage:
4.	<p>For all prescription drug sales by the applicant (includes all sales by the entity identified by the Federal Employer Identification Number provided in this application), for the most recent calendar year ending December 31<sup>st</sup>, provide the percentage of those total sales that WERE NOT prescription drugs (subject to, defined by, or described by s. 503(b) of the Federal Food, Drug &amp; Cosmetic Act).</p> <p>Annual Sales % from January 1, through December 31: _____</p>	Percentage
5.	Does the applicant's establishment repackage prescription drugs (subject to, defined by, or described by s. 503(b) of the Federal Food, Drug & Cosmetic Act)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Does the applicant understand that any establishment operated by the applicant can not distribute any prescription drugs (subject to, defined by, or described by s. 503(b) of the Federal Food, Drug & Cosmetic Act) to any person who is authorized to sell, distribute, purchase, trade or use these drugs on or for any humans?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Are products distributed under this permit intended for export? (Note: A permit may be required for freight forwarders handling products in Florida.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Are all required records stored and maintained at applicant's physical address? (If no, provide the establishments address where all required records will be stored and maintained below.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Physical address where required records are stored Street Address:	
	City:	State:
		Zip Code (+4 optional):
10.	Are the required records computerized, automated or stored electronically? If yes, do you have a back-up procedure to be able to provide required records?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Do you understand that freight forwarders in Florida exporting for you need a permit under Chapter 499, F.S.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Is the applicant licensed by Chapter 465, F.S. as any type of pharmacy? If yes, please provide the Florida pharmacy permit number: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Does the applicant, any of the applicant's parent, sister or subsidiary companies, provide diagnostic, medical, surgical, or dental treatment or care, or chronic or rehabilitative care? If so please list all	<input type="checkbox"/> Yes <input type="checkbox"/> No

	company/companies below. (Use additional sheet(s) if necessary.	
14.	Have you included the \$20,000 bond requirement?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section VIII – If Located in the State of Florida**

DISTRIBUTION ACTIVITIES		
1.	Is the applicant's establishment equipped with an alarm system to detect entry after hours and a security system protecting against theft and diversion? (If yes, provide the types and descriptions of those systems on a separate sheet.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Is there a quarantine area at the applicant's establishment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Is the applicant's establishment equipped with adequate climate controls (including refrigerated and freezing storage if appropriate for the applicant's distributed products) to ensure safe storage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Does the applicant have written policies and procedures to include: the receipt, security, storage, inventory, distribution/disposition of prescription drugs; distributing oldest approved stock first (FIFO); identifying, recording and reporting prescription drug losses and thefts; maintenance, retrieval and retention of required records; prescription drug recalls and withdrawals; natural disasters and other emergencies; segregation and destruction of outdated products; temperature and humidity monitoring?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Provide the date the establishment will be ready and available for inspection. This is the earliest date the application may be deemed complete	___/___/20___

**Section IX– If located in a State other than Florida**

DISTRIBUTION ACTIVITIES			
1.	Provide a valid license/permit number issued by your resident state that authorizes the sale/distribution of prescription drugs from the applicant's address. Attach a copy.		
1.a.	Type of Permit:	Permit No:	
2.	Provide the name, address, and telephone number of the regulatory entity in the resident state that issues the above license/permit.		
2.a.	State Agency Name:		
2.b.	Address:		
	City:	State:	Zip Code:
2.c.	Telephone Number:		



**Section X – Affidavit**

<b>AFFIDAVIT</b>	
<p>Each application for a license or renewal of a license issued by the Department of Business and Professional Regulation shall be signed under oath or affirmation by the owner or corporate officer of the applicant without the need for witnesses unless otherwise required by law.</p> <p>I certify that I am empowered to execute this application as required by Section 559.79, Florida Statutes. I understand that my signature on this application has the same legal effect as if made under oath. To the best of my knowledge, all information contained on this application is true and correct. I understand the falsification of any information on this application may result in administrative action, including a fine, suspension, or revocation of the license.</p>	
Signature of Owner or Officer:*	Date:
Print Name:	Title:

**\* If signed by someone other than an owner or officer, you must submit a letter from an owner or officer authorizing the signer to bind the applicant.**

Mail completed application to:

Department of Business and Professional Regulation  
1940 North Monroe Street  
Tallahassee, FL 32399