

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

Application for Retail Pharmacy Drug Wholesale Distributor Permit
Form No.: DBPR-DDC-218

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

APPLICATION	APPLICATION REQUIREMENTS
<p>Application for Retail Pharmacy Drug Wholesale Distributor Permit</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Enclose the <u>non-refundable</u> biennial fee of \$100.00. <input type="checkbox"/> Make cashier's check, corporate or business check, or money order, to the Florida Department of Business and Professional Regulation or DBPR. <input type="checkbox"/> If you answer "Yes" to any question in Section IV, be sure to provide a detailed explanation along with any relevant documentation. <input type="checkbox"/> Submit photocopy of your Community Pharmacy permit issued by Florida Board of Pharmacy under Chapter 465, F.S. <input type="checkbox"/> If you are a member of a buying group, provide a list of your buying group(s) and a copy of the buying group contract(s). <input type="checkbox"/> Sign and date the Affidavit section of the application.
	<p>Submit the completed application with enclosures to: Department of Business and Professional Regulation Division of Drugs, Devices, and Cosmetics 2601 Blair Stone Road Tallahassee, FL 32399-1047</p>

PLEASE NOTE:

Telephone, email, and fax contact information is used to quickly resolve questions with applications. If such information is not provided, questions regarding applications will be mailed to the application contact's mailing address and may take longer to resolve.

The disclosure of Social Security numbers is mandatory on all professional and occupational license applications, is solicited by the authority granted by 42 U.S.C. §§ 653 and 654, and will be used by the Department of Business and Professional Regulation pursuant to §§ 409.2577, 409.2598, 499.012(4)(a)5.f., 499.012(8)(o), and 559.79(3), Florida Statutes, for the efficient screening of applicant and licensees by a Title IV-D child support agency to assure compliance with child support obligations. It is also required by §559.79(1), Florida Statutes, for determining eligibility for licensure and mandated by the authority granted by 42 U.S.C. § 405(c)(2)(C)(i), to be used by the Department of Business and Professional Regulation to identify licensees for tax administration purposes.

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

Application for Retail Pharmacy Drug Wholesale Distributor Permit
Form No.: DBPR-DDC-218

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 [3324/1020]
<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). [3324/1020] Current Permit Number _____

Section II – Applicant Information

APPLICANT INFORMATION
TAXPAYER IDENTIFICATION NUMBER OR FEDERAL EMPLOYER IDENTIFICATION NUMBER
This is a unique nine-digit number assigned by the Internal Revenue Service (IRS) to business entities operating in the United States for the purposes of identification. When the number is used for identification rather than employment tax reporting, it is usually referred to as a Taxpayer Identification Number (TIN), and when used for the purposes of reporting employment taxes, it is usually referred to as the Federal Employer Identification Number (FEIN).
Applicant's TIN/FEIN: _____
FULL LEGAL NAME
The "full legal name" is the complete name of the business entity that will be operating the establishment. This is generally the name that is on the documents that establish the existence or formation of the business entity. For example, a corporation's full legal name would normally be the name that is found in the corporation's articles of incorporation.
Applicant's Full Legal Name: _____
FICTITIOUS, TRADE OR BUSINESS NAME
If the applicant intends to operate the permitted establishment under a name that is different from the Applicant's Full Legal Name listed above – e.g. fictitious, trade, or business name (also commonly referred to as a "dba", or "doing business as" name), this name must be registered with the Florida Department of State, Division of Corporations. This is the name that will appear on the permit issued to the applicant by the department and must be the name that the applicant uses on operational documents for permitted activities.
<input type="checkbox"/> The applicant WILL NOT operate the permitted establishment under a name that is different from the Applicant's Full Legal Name listed above.
<input type="checkbox"/> The applicant WILL operate the permitted establishment under the following fictitious, trade, or business name: _____
The fictitious, trade, or business name listed directly above is registered with the Florida Department of State, Division of Corporations and the applicant has been issued the following registration number: _____.
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		
The application contact is the person that the department will contact if there are questions regarding the responses provided on or the documentation submitted with the application. The application contact is also the person that will receive all official communication from the department regarding the application.		
Last/Surname:	First:	Middle: Suffix:
Address:		
City:	State:	Zip Code (+4 optional):
Telephone Number:	Fax Number:	
E-Mail Address:		
EMERGENCY CONTACT INFORMATION		
The emergency contact is the person that the department will contact in the case of an emergency. During an emergency, the department may contact this person at times outside of the regular business hours listed below. The contact information provided should be sufficient for the department to reach and communicate with the person listed.		
Last/Surname:	First:	Middle: Suffix:
Position/Title:		
Street Address:		
City:	State:	Zip Code (+4 optional):
Telephone Number:	E-Mail Address:	
OPERATING HOURS		
List the establishment's daily hours of operation in terms of Eastern Time. REMEMBER to circle "a.m." or "p.m." for each time indicated below. The establishment must be open a minimum of 10 total hours per week (M-F) between 8:00 a.m. and 5:00 p.m. local 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.
 N/A (Partnership – General or Sole Proprietorship)

State:

List the name and address of the applicant’s registered agent for service of process in Florida (except Partnership – General or Sole Proprietorship) and provide documentation, such as a print out from the Florida Department of State, Division of Corporations’ webpage, that the applicant’s registered agent is registered with the Florida Department of State, Division of Corporations.
 N/A (Partnership – General or Sole Proprietorship)

Name:

Address:

City:	State:	Zip Code (+4 Optional):
-------	--------	-------------------------

List the name, position/title, social security number, date of birth and address of each owner, partner, member, manager, officer, director, chief executive, or other person who directly or indirectly controls the operation of the business entity, as applicable. For example, corporations would list officers and directors, limited liability companies would list members and managers, etc.

1.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
2.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
3.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
4.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:

5.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
6.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
7.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
8.	Name & Title:	Social Security #:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
List the name, social security number, date of birth and address of each person who owns 10 percent or more of the outstanding stock or equity interest in the business entity. If such person is a business entity, list the business entity name, FEID/FEIN and percentage of ownership and check the box labeled "N/A" for date of birth.				
1.	Name:	SSN/FEID/FEIN#:	Date of Birth: <input type="checkbox"/> N/A	% of Ownership:
	Street Address:	City:	State:	Zip Code:
2.	Name:	SSN/FEID/FEIN#:	Date of Birth: <input type="checkbox"/> N/A	% of Ownership:
	Street Address:	City:	State:	Zip Code:
3.	Name:	SSN/FEID/FEIN#:	Date of Birth: <input type="checkbox"/> N/A	% of Ownership:
	Street Address:	City:	State:	Zip Code:
4.	Name:	SSN/FEID/FEIN#:	Date of Birth: <input type="checkbox"/> N/A	% of Ownership:
	Street Address:	City:	State:	Zip Code:
5.	Name:	SSN/FEID/FEIN#:	Date of Birth:	% of Ownership:

			<input type="checkbox"/> N/A	
	Street Address:	City:	State:	Zip Code:
6.	Name:	SSN/FEID/FEIN#:	Date of Birth: <input type="checkbox"/> N/A:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
7.	Name:	SSN/FEID/FEIN#:	Date of Birth: <input type="checkbox"/> N/A:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
List all trade or business names used by the applicant. Use additional sheet(s) if necessary. If the applicant does not use other trade or business names check this box <input type="checkbox"/> and write N/A on the lines below.				
Is the applicant a subsidiary of another company? (If yes, provide a listing of all parent companies with percentages of ownership. Please note: 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		
Does the applicant, 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 company/companies below. (Use additional sheet(s) if necessary).				<input type="checkbox"/> Yes <input type="checkbox"/> No

Section IV – Background Questions

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, and expiration date in the spaces provided below. Use additional sheets if necessary.)		<input type="checkbox"/> Yes <input type="checkbox"/> No
1.a.	Permit/License Name	Permit/License Type and License Number	Expiration Date

Section VII – Distribution Activity

DISTRIBUTION ACTIVITIES	
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"/> Practitioners licensed in Florida to prescribe and dispense prescription drugs <input type="checkbox"/> Other Retail Pharmacies in the State of Florida <input type="checkbox"/> Modified Class II Institutional Pharmacies in the State of Florida <input type="checkbox"/> Other (explain) _____	
Identify the types of products the applicant will manufacture or distribute under this permit.	
<input type="checkbox"/> Human Prescription Drugs <input type="checkbox"/> Veterinary Prescription Drugs <input type="checkbox"/> Solid Dose <input type="checkbox"/> Repackage – From Bulk <input type="checkbox"/> Liquids (Oral) <input type="checkbox"/> Repackage – From Stock <input type="checkbox"/> Injectables <input type="checkbox"/> Refrigerated (Human, Veterinary, API or otherwise) <input type="checkbox"/> Topical <input type="checkbox"/> Frozen (Human, Veterinary, API or otherwise) <input type="checkbox"/> Dental <input type="checkbox"/> Ophthalmic <input type="checkbox"/> Compressed Medical Gases	
<input type="checkbox"/> Active Pharmaceutical Ingredients (If yes, check the applicable box(es) for your customers): <input type="checkbox"/> Manufacturers <input type="checkbox"/> Pharmacies for Compounding <input type="checkbox"/> Other explain _____	
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.	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
2.	Are all required records stored and maintained at applicant's physical address? (If no, provide the establishment's address where all required records will be stored and maintained below.)
	<input type="checkbox"/> Yes <input type="checkbox"/> No

3.	Physical address where required records are stored Street Address:		
	City:	State:	Zip Code (+4 optional):
4.	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 <input type="checkbox"/> Yes <input type="checkbox"/> No	
5.	Section 499.0121(2), F.S., requires establishments to be equipped with: a) an alarm system to detect entry after hours and b) a security system that provides protection against theft or diversion that is facilitated or hidden by tampering with computers or electronic records. Please provide a written description of the alarm and security systems that includes both the type of systems used and how the systems are monitored. Alarm system description included? Security system description included?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
6.	Is there a quarantine area at the applicant's establishment? (If not, please explain on a separate sheet.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7.	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? (If not, please explain on a separate sheet.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8.	Does the establishment's wholesale distribution activity represent more than 30% of the total annual purchases of prescription drugs for the establishment? (If yes, the applicant must obtain a prescription drug wholesale distributor permit.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9.	Will prescription drug distributions under the permit be limited to practitioners licensed in Florida to prescribe and dispense prescription drugs, to other retail pharmacies in this state, or Modified Class II Institutional Pharmacies in this state? (If no, please explain on a separate sheet.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10.	Does the applicant intend to distribute any compounded medications under the permit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11.	Will all records pertaining to a wholesale transaction be maintained separate and distinct from dispensing records? (If no, please explain on a separate sheet.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12.	Is the applicant a member of a buying group? (If yes, provide a list of your buying group(s) and a copy of the buying group contract(s)).	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13.	Is the applicant licensed under Chapter 465, F.S., as a "Community Pharmacy"? (If yes, provide a copy of the community pharmacy permit and the permit number.) Permit Name: Permit Number:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14.	Is the applicant licensed by Chapter 465, F.S., as any other type of pharmacy? (If yes, provide permit name and number in the spaces below.) Permit Name: Permit Number:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15.	Will the applicant provide prescription services to the general public?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
16.	Does the applicant have on hand adequate inventory to fill a variety of prescriptions for a variety of medical conditions that would be required by the public generally?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
17.	Does the applicant provide prescription services to a limited patient population? (If yes, explain on a separate sheet)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

18.	Does the applicant provide diagnostic, medical, surgical, or dental treatment or care, or chronic or rehabilitative care? (If yes, please explain on a separate sheet.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
19.	Are purchases of prescription drugs by the retail pharmacy applicant made at the fair market value for retail pharmacies? (If no, please explain on a separate sheet.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
20.	Does the applicant's retail pharmacy or any other business located at the same address purchase prescription drugs under special purchasing contracts, arrangements, or discounts for health care entities? (If yes, explain in detail the contractual arrangement the pharmacy has on a separate sheet.)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section IX – Affidavit

AFFIDAVIT	
<p>Pursuant to s. 559.79, F.S., 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 applicant, or owner or chief executive of the applicant without the need for witnesses unless otherwise required by law.</p> <p>Pursuant to s. 559.791, F.S., any license issued by the Department of Business and Professional Regulation which is issued or renewed in response to an application upon which the person signing under oath or affirmation has falsely sworn to a material statement, including, but not limited to, the names and addresses of the owners or managers of the licensee or applicant, shall be subject to denial of the application or suspension or revocation of the license, and the person falsely swearing shall be subject to any other penalties provided by law.</p> <p>I understand that the issuance of a permit by the department only authorizes the applicant to conduct regulated activities in the state of Florida under the name in which the permit is issued. If the permit is issued in the name of a dba the applicant may only conduct business in Florida in the name of the dba.</p> <p>I further understand that providing additional dba names to the department as part of the application process is not, upon licensure, an authorization to conduct business in Florida under the name of those additional dba's.</p> <p>I certify that I am empowered to execute this application as required by s. 559.79, F.S., 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:

Mail completed application to:
Department of Business and Professional Regulation
2601 Blair Stone Road
Tallahassee, FL 32399-1047