

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

**Application for Veterinary Prescription Drug Wholesale Distributor Permit**  
**Form No.: DBPR-DDC-216**

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

APPLICATION	APPLICATION REQUIREMENTS
<p><b>Application for Veterinary Prescription Drug Wholesale Distributor Permit</b></p>	<p><input type="checkbox"/> Establishments* located in the state of Florida, enclose <b>non-refundable</b> \$1,150.00 fee, which includes a \$1,000.00 biennial application fee and a \$150.00 initial application/on-site inspection fee.</p> <p><input type="checkbox"/> Establishments* located outside the state of Florida, enclose <b>non-refundable</b> \$1,000.00 biennial application fee.</p> <p><input type="checkbox"/> Make cashier's check, corporate or business check, or money order payable to the Florida Department of Business and Professional Regulation or DBPR.</p> <p><input type="checkbox"/> If the applicant answered "Yes" to any question in Section IV, enclose a detailed explanation along with any relevant documentation.</p> <p><input type="checkbox"/> Sign and date the Affidavit section of the application.</p> <p>*Florida law generally defines "establishment" to mean a place of business at one general physical location. As used in this application, "the establishment" refers to the physical address of the establishment to be permitted.</p>
	<p>Submit the completed application with enclosures to:            Department of Business and Professional Regulation            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), 499.63(2), 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.

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**Form No.: DBPR-DDC-216**

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 [3342/1020]
<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). [3342/1020] Current Permit Number _____

**Section II – Applicant Information**

APPLICANT INFORMATION
<b>TAXPAYER IDENTIFICATION NUMBER OR FEDERAL EMPLOYER IDENTIFICATION NUMBER</b>
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: _____
<b>FULL LEGAL NAME</b>
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: _____
<b>FICTITIOUS, TRADE OR BUSINESS NAME</b>
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: _____.
<b>APPLICANT'S MAILING ADDRESS</b>

Street Address or P.O. Box:		
City:	State:	Zip Code (+4 optional):
<b>PHYSICAL ADDRESS OF ESTABLISHMENT TO BE PERMITTED</b>		
Street Address:		
City:	State:	Zip Code (+4 optional):
County (if Florida address):	Country:	
Telephone Number:	Fax Number:	
Email Address:		
<b>APPLICATION CONTACT</b>		
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:		
<b>EMERGENCY CONTACT</b>		
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 in the event of an emergency.		
Last/Surname:	First:	Middle: Suffix:
Position/Title:		
Street Address:		
City:	State:	Zip Code (+4 optional):
Telephone Number:	E-Mail Address:	
<b>OPERATING HOURS</b>		
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., 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 or Country:

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):
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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 enter "N/A" for date of birth.				
1.	Name:	SSN/FEID/FEIN#:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
2.	Name:	SSN/FEID/FEIN#:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
3.	Name:	SSN/FEID/FEIN#:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
4.	Name:	SSN/FEID/FEIN#:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
5.	Name:	SSN/FEID/FEIN#:	Date of Birth:	% of Ownership:

	Street Address:	City:	State:	Zip Code:
6.	Name:	SSN/FEID/FEIN#:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
7.	Name:	SSN/FEID/FEIN#:	Date of Birth:	% of Ownership:
	Street Address:	City:	State:	Zip Code:
8.	Name:	SSN/FEID/FEIN#:	Date of Birth:	% 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, using additional sheet(s) if necessary. <u>Note</u> : A permit issued pursuant to this applicant 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**



**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.)		<input type="checkbox"/> Yes <input type="checkbox"/> No
1.a.	Permit/License Name	Permit/License Type and Number	Expiration Date
2.	Does the location for which you are applying sell veterinary prescription drugs from or into Florida? (If no, provide the name and address from which the veterinary prescription drugs are sold into Florida in the spaces provided below. Use additional sheets if needed.)		<input type="checkbox"/> Yes <input type="checkbox"/> No
2.a.	Name	Physical Address	Florida Permit/License Number
3.	Does the location for which you are applying ship veterinary prescription drugs into Florida? (If no, provide the name and address of all locations that ship veterinary prescription drugs into Florida on your behalf in the spaces provided below. Use additional sheets if needed.)		<input type="checkbox"/> Yes <input type="checkbox"/> No
3.a.	Name	Physical Address	Florida Permit/License Number
4.	Does the applicant intend to engage in the wholesale distribution of veterinary prescription drugs, which the applicant did not manufacture, which are subject to, defined by, or described by s. 503(b) of the Federal Food, Drug, and Cosmetic Act? (If yes, the applicant needs to be permitted as a prescription drug wholesale distributor, an out-of-state prescription drug wholesale distributor, or a limited prescription drug veterinary wholesale distributor, in lieu of a veterinary prescription drug wholesale distributor.)		<input type="checkbox"/> Yes <input type="checkbox"/> No



**Section VII – Veterinary Prescription Drug 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"/> Active Pharmaceutical Ingredients			
Note: If you sell or distribute any prescription drugs approved for human use, you do not qualify for this permit.			
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 establishments 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
5.	Does the applicant manufacture veterinary prescription drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Does the applicant repackage veterinary prescription drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Is the applicant a private label distributor of veterinary prescription drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Do you understand that freight forwarders in Florida exporting for you or your customer need a permit under Chapter 499, F.S?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	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 on a separate sheet(s).	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

<b>DISTRIBUTION ACTIVITIES</b>		
1.	<p>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.</p> <p style="text-align: right;">Alarm system description included? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: right;">Security system description included? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
2.	<p>Is there a quarantine area at the applicant's establishment? (If not, please explain on a separate sheet.)</p> <p style="text-align: right;">Explanation included? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	<p>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.)</p> <p style="text-align: right;">Explanation included? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	<p>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?</p> <p>Please provide copies of the applicant's written policies and procedures on:</p> <ul style="list-style-type: none"> <li>a. Receipt, security, storage, inventory, distribution/disposition of prescription drugs.</li> <li>b. Distributing oldest approved stock first (FIFO).</li> <li>c. Identifying, recording and reporting prescription drug losses and thefts.</li> <li>d. Maintenance, retrieval and retention of required records.</li> <li>e. Prescription drug recalls and withdrawals.</li> <li>f. Natural disasters and other emergencies.</li> <li>g. Segregation and destruction of outdated prescription drugs.</li> <li>h. Temperature and humidity monitoring.</li> <li>i. Product tracing and other DSCSA requirements.</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No  Policy Attached?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
5.	<p>Provide the date the establishment will be ready and available for inspection. This is the earliest date the application may be deemed complete.</p>	___/___/20___

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

<b>DISTRIBUTION ACTIVITIES</b>		
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 Number:
2.	Provide the name, address, and telephone number of the regulatory entity in the resident state that issues the above license/permit.	

	State Agency Name:		
2.a.	Address:		
	City:	State:	Zip Code:
2.b.	Telephone Number:		

**Section X – Affidavit**

<b>AFFIDAVIT</b>	
<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