

**APPLICATION FOR NON-RESIDENT MANUFACTURER,  
WHOLESALE-REPACKER AND/OR WHOLESALE OF  
PRESCRIPTION DRUGS AND/OR DEVICES  
REGISTRATION IN NEW YORK STATE**

☐ **P 5** **\$825** **I R**

**PLEASE READ CAREFULLY**

The New York State Board of Pharmacy must approve this application before a registration will be issued. If changes are made during the application process, you may need to submit a new application with the appropriate fees. Any application not completed within 60 days of receipt may be deemed withdrawn by the Board of Pharmacy. Fees applied to this application are not transferable and are not refundable.

Registration Number: \_\_\_\_\_

Registered as of: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**PLEASE PRINT LEGIBLY OR TYPE**

☐ Name Change

☐ Relocation Change

Endorsement Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Staff Processor: \_\_\_\_\_

Approved Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Approved by: \_\_\_\_\_

**1** Name of Wholesaler as registered in your **resident state**:

**2** Trade Name/Assumed Name as registered in **resident state**:

**3** Address

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**4** Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**5** Federal Employer ID Number: \_\_\_\_\_

**6** Indicate whether this application is for:

☐ New Wholesaler (\$825 fee)

☐ Change of Location (No fee if within resident state)

☐ Transfer of Ownership (\$825 Fee)

☐ Name Change (No change in ownership) (No Fee)

**7** If this is a **transfer of ownership, change of name or change of location**, indicate:

Previous Name: \_\_\_\_\_ Previous License/Permit/Registration number: \_\_\_\_\_

Previous Address: \_\_\_\_\_

**8** **Type of Registrant:** ☐ Manufacturer ☐ Repacker - Drugs ☐ Repacker - Medical Gases ☐ Wholesaler (Distributor)

**9** **Type of Wholesaler:**

☐ Full Line ☐ Domestic Broker ☐ Import/Export Broker ☐ Reverse Distributor ☐ Specialty: \_\_\_\_\_

**10** Resident State: \_\_\_\_\_ Resident State License/Permit/Registration number: \_\_\_\_\_

Date Issued: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**11** **Please indicate type of ownership:**

☐ Individual

☐ Corporation for profit

☐ LLC for profit

☐ Partnership/LLP for Profit

☐ Government owned

☐ Corporation not-for-profit

☐ LLC not-for-profit

☐ Partnership/LLP not-for-profit

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Companies who do business in New York State must have a registered agent for service for process in New York State, which is the contact person or agent to receive legal papers when a corporation is served for a legal reason.

Name of resident agent for service of process in New York: \_\_\_\_\_

Agent's phone number: \_\_\_\_\_

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**This wholesaler will ship to: (Check all that apply)**

- ☐ Pharmacies      ☐ Dentists      ☐ Hospitals without pharmacies  
☐ Hospitals      ☐ Veterinarians      ☐ Clinical/Surgical Centers  
☐ Physicians      ☐ Other licensed healthcare practitioners (Please specify) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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**VAWD Accreditation**

The National Association of Boards of Pharmacy's (NABP) Verified Accredited Wholesale Distributors (VAWD) accreditation is designed to protect the public from counterfeit drugs entering the U.S. drug supply.

Has your facility obtained VAWD accreditation?

☐ Yes VAWD Accreditation number \_\_\_\_\_ Accreditation date \_\_\_\_\_

☐ No Applied for VAWD Accreditation on \_\_\_\_\_

☐ No Have not yet applied for VAWD Accreditation

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**Type of products this wholesaler will handle: (check all that apply)**

- ☐ Prescription drugs (excluding medical gases)  
☐ Nonprescription drugs  
☐ Veterinary drugs  
☐ Vitamins  
☐ Crude drugs, botanicals, medicinal chemicals  
☐ Serums, toxins, vaccines and similar biologicals  
☐ Devices, hypodermic syringes, needles, etc.  
☐ Compressed medical gasses  
☐ Medical cosmetics  
☐ Other (Please specify) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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Days and hours of operation of the wholesaler: \_\_\_\_\_

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All pre-registration correspondence should be mailed to:

☐ Wholesaler address indicated on page 1 of this application.

☐ **Different address** than wholesaler. All pre-registration correspondence should be mailed to the following address.

Number and street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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**Contact person to clarify information provided on this application:**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

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Submit Certification/Verification of License/Permit/Registration From Your Resident State.

**Members, Partners, Owners or Corporate Officers (please print)**

First Name

Last Name

Title

First Name

Last Name

Title

First Name

Last Name

Title

First Name

Last Name

Title

First Name

Last Name

Title

**Verification with Acknowledgment** (Notarization Required)**Verification**

By signing below, I verify that the information on this application is true and accurate. I further verify that the wholesaler applicant has complied in the past and will comply in the future with all lawful requests for information from the regulatory agencies of all states in which it is licensed or registered, including New York State. I further certify that the wholesaler applicant will maintain records of drugs distributed or wholesaled in New York State for five years, in a manner which makes these records readily retrievable and identifiable from other business records of the wholesaler. I verify that I am familiar with the laws, rules and regulations available at [www.op.nysed.gov/prof/pharm/pharmlaw.htm](http://www.op.nysed.gov/prof/pharm/pharmlaw.htm); I have read them and understand my responsibilities to the New York State Board of Pharmacy and the New York State Education Department. In addition, if distributed or wholesaled drugs are controlled substances, they shall be distributed or wholesaled in accordance with Article thirty-three of the Public Health Law and Part 80 of the Department of Health's Commissioners Regulations, Article thirty-three and Part 80 can be accessed at [www.health.ny.gov/professionals/narcotic](http://www.health.ny.gov/professionals/narcotic). Questions on controlled substances should be directed to the New York State Department of Health's Bureau of Narcotic Enforcement at 518-402-0707.

\_\_\_\_\_  
 Authorized Signature (Member, Partner, Owner, Corporate Officer or Other authorized person)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name

\_\_\_\_\_  
 Title

**Notary**

State of \_\_\_\_\_ County of \_\_\_\_\_ On the  
 \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_ before me, the above, personally appeared  
 \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory  
 evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the  
 application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and  
 correct.

\_\_\_\_\_  
 Notary Public signature

\_\_\_\_\_  
 Notary ID number

**Notary Stamp**

Expiration date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
                             Month                      Day                      Year

- To assure prompt filing, please be sure to complete all portions of this **application**
- Send a fee of \$825\*
- Please make check or money order payable to the **New York State Education Department**. DO NOT SEND CASH. Payments made outside the United States should be made by check or draft on a United States bank in United States currency.

**New York State Education Department  
 Office of the Professions  
 Board of Pharmacy  
 2nd Floor West Wing  
 89 Washington Avenue  
 Albany, NY 12234**

\*An application fee is required for "Registration of Wholesaler" and "Transfer of Ownership." **No fee** is required for Change of Location or Name Change. Change of location from one state to another requires a new application to be submitted.