Alabama State Board of Pharmacy
New Wholesale Distribution Application

Date Received
Office Use Only

Wholesale Distributor:

A person other than a manufacturer, the co-licensed partner of a manufacturer, a third-party logistics provider, or a repackager, engaged in the business of distributing drugs and medicines for resale to pharmacies, hospitals, practitioners, government agencies, or other lawful outlets permitted to sell drugs or medicines.

- Please be sure that you have reviewed the license type definitions and selected the proper new application.
- Application **must be signed by the owner, officer, or CEO only**. Power of Attorney's will not be accepted.
- Follow all directions completely as failure to submit required documentation will cause delays in processing your new application.
- You must submit all required documentation with the application packet. Forms will not be pulled from other applications. Incomplete submissions could result in withdrawal of your application. **Applications fees are non-refundable.**
- If additional forms are needed, please make copies. If additional space is required to answer a question, please attach the information on a separate sheet of paper.
- Section A is the **check list**. The documents listed are required for submission with the new application packet. All applicants must comply, or the application will be returned.
- Additional information may be requested through a deficiency email based on information provided on the application. This is part of our detailed comprehensive review process. The applicant will have **30 days from the date of the email** to comply to the deficiency email. If compliance is not met within 30 days, then the application will be considered abandoned and the application will be withdrawn, and no refunds will be issued. If the applicant complies the documents will be reviewed, then a permit will be issued, or another deficiency email will be issued for additional information. Again, this is part of our comprehensive review process. Multiple deficiency emails could be submitted during a review process. Due to the volume of applications received, weekly status reports will not be possible.
- Section B is **Ownership** and is based on the answer chosen in Section 6 of the application. For Example: If the selection is D, Corporation, then you would refer to Section B – F and provide the forms in Section D, for Corporation. Under each form are the instructions and additional information required to complete this section. This process is the same for section B – F. The applicant may print or copy The Individual History Affidavit Form and Business History Affidavit Form as many times as applicable.

Mail Completed Applications to:
Alabama Board of Pharmacy
111 Village Street
Birmingham, AL 35242

I. Check List

(Section A) Required for All Applicants

*All applicants **must** complete and submit the following documents:*

☐ Completed **New Wholesale Distribution Application**

☐ **Proof of entity (foreign or domestic) registration with the Alabama Secretary of State**. www.sos.state.al.us

☐ **Payment Form and check if applicable (Application fees are non-refundable)**

- New Permit Fee $750 Controlled Substance Permit Fee $600.
- *These are two separate fees, if you need a controlled substance permit the total cost will be $1,350.00*

☐ **DEA Certificate (copy) or Controlled Substance Waiver**

- If you are applying for a controlled substance permit you will need to provide a copy of your DEA certificate.
- All other applicants must complete the **Controlled Substance Waiver**.

☐ **Facility Designated Representative** (Section 5 of application)

- This must be a person of authority that works at the applicant facility.
- An **Individual History Affidavit Form** must be completed for this person.

☐ **Copy of Home State License**

- This must be a copy of the actual certificate.
- If your state does not require your facility to have license, provide proof of exemption.

☐ **Verification of the Home State License**

- This can be a current online verification from the home state issuing agency, but the printed verification should be within the past 30 days.
- Verifications mailed directly to our office from other regulatory agencies will not be accepted. The verification must be submitted with all other required documentation as part of the original submission.
- If your state does not require your facility to have license, provide proof of exemption.

☐ **Third-Party Logistics Providers Contracts** (Section 3 of application)

- Copy of the first page and signature page of contracts with your contract third-party logistics provider(s).

☐ **Proof of reporting to the FDA Wholesale Distributor and Third-Party Logistics Reporting Site**

- All Wholesale Distributors of Human Prescription Drugs must report to the FDA Wholesale Distributor and Third-Party Logistics Providers Reporting Site.
- You can provide a current screen shot of the database showing your current reporting.

☐ **Application Contact Form**

- One contact per new application only.

☐ **Additional Information may be requested in the Application**

- Read over the application carefully for any additional information that may be required.
- Failure to provide the additional information will delay/prevent processing and the issuing of a permit.

II. Ownership: Section B-F is based on the answer chosen in Section 6 of the application.

(Section B) Individual Owner

☐ **Individual History Affidavit Forms**
Complete one form for Owner(s) listed in section 6 of the application.

☐ **Business History Affidavit Forms**
Complete one form for the Applicant Business.

(Section C) Partnership

☐ **Individual History Affidavit Forms**
Complete one form for each Partner/Authorized Agent listed in section 6 of the application.

☐ **Business History Affidavit Forms**
Complete one form for the Applicant Business and any Entity Owner listed in section 6 of the application.

☐ **Partnership Agreement**
Current executed agreement

(Section D) Corporation

☐ **Individual History Affidavit Forms**
Complete one form for each owner, officer, stockholder, and executive officer listed in section 6 of the application.

☐ **Business History Affidavit Forms**
Complete one form for the Applicant Business and any Entity Owner listed in section 6 of the application.

☐ **Ownership Organizational Chart**
Provide an organizational chart that clearly outlines the company's ownership structure and includes percentages for each party.

(Section E) Publicly Traded Corporation

☐ **Individual History Affidavit Forms**
Complete one form for each executive officer and any authorized agent listed in section 6 of the application.

☐ **Business History Affidavit Forms**
Complete one form for the Applicant Business and any Entity Owner listed in section 6 of the application.

(Section F) Limited Liability Company

☐ **Individual History Affidavit Forms**
Complete one form for each member, executive officer, and authorized agent listed in section 6 of the application.

☐ **Business History Affidavit Forms**
Complete one form for the Applicant Business and any Entity Owner listed in section 6 of the application.

☐ **Ownership Organizational Chart**
Provide an organizational chart that clearly outlines the company's ownership structure and includes percentages for each party.

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1. Applicant Business Details

Name of Business:			
All other trade or business names ("DBA" names) used by applicant:			
Business Address: *Number and Street*			
City	*State*	*Zip*	*County (If in Alabama)*
Telephone Number for Business:		**Federal Tax ID Number/TIN:**	

1. Hours of Operations

Monday - Friday	*Saturday*	*Sunday*

2. Business Operations

2a. Is this facility a "Reverse Distributor Only" ☐ **Yes*** ☐ **No**

please indicate below what types of businesses, you collect product from (2b) and what type of products are collected (2c)

2b. The Applicant Business Sells to: *(Mark all that apply)*

- ☐ Community pharmacies
- ☐ Hospitals
- ☐ Wholesale Distributors
- ☐ Licensed Prescriber
- ☐ Repackagers
- ☐ Other: _____

2c. Type of product(s) distributed: *(Mark all that apply)*

- ☐ Controlled substances
- ☐ Prescription drugs (human)
- ☐ Precursor chemicals
- ☐ Devices
- ☐ Veterinary
- ☐ API
- ☐ Other: _____

2d. Do you currently have a federal registration with the Drug Enforcement Administration?

- ☐ Yes DEA #: _____ Exp. Date: _____
- ☐ No - Please complete Controlled Substance Waiver Form found attached.

2e. Mark all schedules listed on your DEA registration:

- ☐ Schedule II
- ☐ Schedule III
- ☐ Schedule IV
- ☐ Schedule V

Is the applicant business reporting to the FDA Wholesale Distributor and Third-Party Logistics Providers Reporting Site?	☐ **Yes** ☐ **No**
Has this facility been inspected by the FDA? ***(If marked "yes", please attach a copy of the inspection)***	☐ **Yes** ☐ **No**
Is the applicant business VAWD accredited?	☐ **Yes** ☐ **No**

3. Possession of Product

3a.Does this facility take physical possession of product (drugs/devices) at any time?	☐ **Yes** ☐ **No (list third party providers)**

3b.Third Party Logistics Provider Details ☐ Not Applicable

Name	*Alabama Permit #*
Address:	

3b. If there are multiple Third Party Logistics providers, provide a list of additional Third Party Logistic providers with the detail listed above in 3b if applicable.

4. Discipline/Settlement

Has this business surrendered, had suspended, lost its license or received any other disciplinary action?	☐ **Yes** ☐ **No**
Has any final judgment been entered or settlement reached resulting from a claim or action for damages caused by any error, omission or negligence in the performance of any pharmacy or pharmaceutical professional services?	☐ **Yes** ☐ **No**

If you answered "yes" to any of the above questions attach a copy of the official documents and an explanation to the application.

5. Facility Designated Representative: This must be a person of authority that work at the applicant's facility.

5a. In addition, an Individual History Affidavit Form must be completed for this person.

Name	**Date of Birth**	**Social Security Number**
Title	**Email**	
Phone Number	**Home Address:** *Number and Street*	
City	*State*	*Zip*

6. Ownership: ***Section B-F is based on the answer chosen in Section 6 of the application.***

Ownership details must be provided for the applicant business. These details may include a parent company, and officers, partner, or members (as appropriate) for the business. (See section B – F)

Type of Ownership:

☐ Individual Owner ☐ Partnership ☐ Corporation (Not publicly traded) ☐ Publicly Traded Corporation

☐ Limited Liability Company

6a. Entity Owners

If the applicant business is owned by an entity (not a natural person), the applicant must identify each parent company that has 10% or more ownership

Name	**FEIN/TIN#**	**% of Ownership**	**Phone Number**
Address: *Number and Street*	*City*	*State*	*Zip*
Authorized Agent	**Authorized Agent Phone Number:**		

Name	**FEIN/TIN#**	**% of Ownership**	**Phone Number**
Address: *Number and Street*	*City*	*State*	*Zip*
Authorized Agent	**Authorized Agent Phone Number:**		

Name	FEIN/TIN#	% of Ownership	Phone Number
Address: *Number and Street*	*City*	*State*	*Zip*
Authorized Agent	**Authorized Agent Phone Number:**		

6b. Natural Person Ownership

Complete the details below for each owner, partner, member and/or stockholder (as appropriate) with 10% or more ownership that is a natural person owner for this business. If there are no natural person owners for this business, list the appropriate owners, members, or partners that are natural persons for parent companies listed in the previous section.

Name	Title	Date of Birth	Social Security Number
Address: *Number and Street*	*City*	*State*	*Zip*
Phone Number	**Email Address**	**% of Ownership**	

Name	Title	Date of Birth	Social Security Number
Address: *Number and Street*	*City*	*State*	*Zip*
Phone Number	**Email Address**	**% of Ownership**	

Name	Title	Date of Birth	Social Security Number
Address: *Number and Street*	*City*	*State*	*Zip*
Phone Number	**Email Address**	**% of Ownership**	

6c. Executive Officer(s):

Complete the details for each executive officer for the business. If there are no officers for the business list the officers for the parent company listed in the Entity Owners section. At a minimum you must include the President/CEO, Vice President, Secretary, and Treasurer.

Name	Title	Date of Birth	Social Security Number
Address: *Number and Street*	*City*	*State*	*Zip*
Phone Number	**Email Address**		

Name	Title	Date of Birth	Social Security Number
Address: *Number and Street*	*City*	*State*	*Zip*
Phone Number	**Email Address**		

Name	Title	Date of Birth	Social Security Number

Address:	*Number and Street*	*City*	*State*	*Zip*

Phone Number	Email Address

Name	Title	Date of Birth	Social Security Number

Address:	*Number and Street*	*City*	*State*	*Zip*

Phone Number	Email Address

In signing Wholesale Distributor applicant agrees to:

- Provide names of trading partners, suppliers and purchasers, when requested.
- Comply with federal and state regulations regarding import and export regulations.
- Assist and cooperate with state of Alabama inspections/investigations regarding operation of businesses and facility (s) covered by this application.

It is affirmed that all information provided herein is true and correct and it is recognized that providing false information may result in disciplinary action. It is understood that there must be compliance with the provisions of the Alabama Pharmacy Act, the Rules of the Board and all other applicable statutes and rules.

_____ _____

Signature Owner, Officer, or CEO only Title

_____ _____

Printed Name Date

Are you a US Citizen? YES NO If NO, Submit documentation of legal status in this country.

FORM MUST BE NOTARIZED

Subscribed and sworn to before me this _____day of _____, 20_____ A.D.
APPLICATION MUST BE NOTARIZED

_____

Notary Public (seal)

INDIVIDUAL HISTORY AFFIDAVIT FORM

Date Received
Office Use Only

Name: *First*	*MI*	*LAST*	**Date of Birth:**
Social Security Number:	**Telephone Number:**	**Email Address:**	
Home Address: *Number and Street*	*City*	*State*	*Zip*

Company Name:	**Permit Number:**
Company Address: *Number and Street*	*City* *State* *Zip*

Position with Business: *(Check all that apply)*

☐ Owner ☐Partner ☐ Officer ☐ Stockholder ☐ Member ☐ Designated Representative

☐ Other: Specify_____

Provide details for any professional or vocational license held in the past five years. (Pharmacist, physician, dentist, veterinarian attorney, accountant etc.)

License Held	State Issued	License Number

1.	**Have you ever been an owner, partner, officer, or member of any business (partnerships, corporation, firm, or association) whose license was denied, revoked, suspended, surrendered or placed on probation?**	**☐ Yes ☐ No**
2.	**Have you ever had any professional or vocational (e.g. pharmacist, technician, pharmacy) license/registration revoked, suspended, denied, suspended, placed on probation or any other disciplinary action by any Federal or State authority?**	**☐ Yes ☐ No**
3.	**Have you ever been arrested and/or convicted of a felony or misdemeanor (excluding minor traffic violations that do not involve drugs or alcohol) in any state?**	**☐ Yes ☐ No**
4.	**Has any final judgment been entered or settlement reached resulting from a claim or action for damages caused by any error, omission or negligence in the performance of any pharmacy or pharmaceutical professional services?**	**☐ Yes ☐ No**

If you answered "Yes" to any of the above questions you must attach an explanation that includes the date, license type, license number, your position, state issued, and a copy of any arrest records, board orders, or court proceedings.

It is affirmed that all information provided herein is true and correct and it is recognized that providing false information may result in disciplinary action. It is understood that there must be compliance with the provisions of the Alabama Pharmacy Act, the Rules of the Board and all other applicable statutes and rules.

_____ _____

Signature Title

_____ _____

Printed Name Date

FORM MUST BE NOTARIZED

Subscribed and sworn to before me this _____day of _____, 20_____ A.D.

APPLICATION MUST BE NOTARIZED_____

Notary Public (seal)

10/18

NEW BUSINESS HISTORY AFFIDAVIT FORM

Date Received Office Use Only

Permit Holder (Business) Name:			**Permit Number:**
Company Address: *Number and Street*	*City*	*State*	*Zip*

Name of Entity Owner:			**FEIN/TIN#**
Address: *Number and Street*	*City*	*State*	*Zip*
Name of Authorized Agent:			**Phone Number:**
Authorized Agent's Position: ☐ **Owner** ☐**Member** ☐ **Manager** ☐ **Principal** ☐ **Executive Director**			

1.	**Has this business ever been an owner, partner, officer, or member of any business (partnerships, corporation, firm, or association) whose license was denied, revoked, suspended, surrendered or placed on probation?**	☐ **Yes** ☐ **No**
2.	**Has this business ever been in violation of any part of the Alabama Pharmacy Law or its regulations?**	☐ **Yes** ☐ **No**
3.	**Has this business ever been charged and/or convicted of violating any Federal or U.S. State law?**	☐ **Yes** ☐ **No**
4.	**Has any final judgment been entered or settlement reached resulting from a claim or action for damages caused by any error, omission or negligence in the performance of any pharmacy or pharmaceutical professional services?**	☐ **Yes** ☐ **No**

If you answered Yes to any of the above questions you must attach an explanation that includes the date, license type, license number, your position, state issued, and a copy of any arrest records, disciplinary orders, or court proceedings.

It is affirmed that all information provided herein is true and correct and it is recognized that providing false information may result in disciplinary action. It is understood that there must be compliance with the provisions of the Alabama Pharmacy Act, the Rules of the Board and all other applicable statutes and rules.

_____ _____

Signature Owner, Officer, or CEO only Title

_____ _____

Printed Name Date

FORM MUST BE NOTARIZED

Subscribed and sworn to before me this _____day of _____, 20_____ A.D.
APPLICATION MUST BE NOTARIZED

_____

Notary Public (seal)

CONTROLLED SUBSTANCE WAIVER

Date Received
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Applicant Business Information

Name of Business:			
Address of Business: Number and Street	*City*	*State*	*Zip Code*

I am hereby requesting the Board to issue only a permit and that no activities requiring a controlled substance registration will be performed during the referenced period. I understand that providing a false statement or engaging in any activity requiring a controlled substance registration may result in discipline.

_____ _____

Signature Owner, Officer, or CEO only Title

_____ _____

Printed Name Date

FORM MUST BE NOTARIZED

Subscribed and sworn to before me this _____day of _____, 20_____ A.D.
APPLICATION MUST BE NOTARIZED

_____

Notary Public (seal)

Application Contact Person

Date Received
Office Use Only

Applicant Business Information

Name of Business:			
Address of Business: Number and Street	*City*	*State*	*Zip Code*

Please provide the best contact details for the person to be contacted regarding any deficiencies, questions, or concerns regarding this application. All official correspondence regarding this application will be directed to this individual only.

Name:	*Telephone Number:*
Mailing Address: Number and Street *City* *State* *Zip Code*	
Email Address:	

_____ _____

Signature Owner, Officer, or CEO only Title

_____ _____

Printed Name Date

PAYMENT FORM

Date Received
Office Use Only

You may pay by check or credit card. Please denote below which method of payment you will be sending.

Business Name: _____ Permit # _____

☐ **Check #_____is attached – Please make check payable to the Alabama State Board of Pharmacy**

☐ **Charge fees to credit card (There will be an additional 5% transaction fee)**

Credit Card Type: Visa MasterCard Discover American Express (please circle)

Card Number: _____

Expiration Mo/Yr: _____/_____ (MM/YY)

Security Code _____

Card Holder Name: _____

Complete Billing Address: _____

_____

(City) (State) (Zip)

Signature of Card Holder_____

MUST be Signature of Card Holder

If you need a transaction receipt, please provide an email address.

_____