



# Idaho State Board of Pharmacy

3380 Americana Terrace #320  
208/334-2356

PO Box 83720

Boise ID 83720-0067  
208/334-3536 Fax

## **Instructions – Wholesale/Distributor License Application**

The following documents are required to be included with the application for Wholesaler of Prescription & Non-Prescription Drugs and Legend Medical Devices. Application and supporting documentation must be typed or neatly printed. Any application packet that includes unreadable documents will be returned unprocessed.

- \$130 Fee for Wholesale License; additional \$100 fee to distribute controlled substances
- List of all trade names used by the applicant – *IC 54-1753 (2) (b)*
- List of contact person, address and telephone number for each facility used by the applicant for the storage, handling and distribution of prescription drugs – *IC 54-1753 (2) (c)*
- List of each person who is an owner or an operator of the applicant - *IC 54-1753 (2) (e)*
- Provide a copy of the resident state license and DEA certificate information if distributing controlled substances. List all other licenses and permits issued to the applicant by any other state that authorizes the applicant to purchase or possess prescription drugs. - *IC 54-1753 (2) (f)*
- Designated Representative's Personal Information Statement including completed fingerprint card and recent photo, fingerprints will be sent to Idaho State Police for an FBI background check - *IC 54-1753 (2) (g)*
- A copy of the current facility inspection report issued by the resident state, FDA or VAWD - ***please note Idaho is unable to issue a Wholesale license without an inspection report***

***In order to be processed the application must be complete. If a question does not apply to applicant use N/A.***



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## Application for Idaho License for Wholesaler of Prescription & Controlled Substance Drugs

Type of Application:  New  Reinstatement  Ownership Change  Name Change  Address Change

Previous #: \_\_\_\_\_ Previous Name: \_\_\_\_\_

Name of Business: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip+4: \_\_\_\_\_ +

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip+4: \_\_\_\_\_ +

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Designated Representative: \_\_\_\_\_

Business Owner: \_\_\_\_\_

Type of Ownership: *(Attach listing of officers, partners, etc., with addresses and phone for each)*

Partnership  Sole Proprietorship  Corporation  Limited Liability

Type of Operation: *(Circle all that apply)*

Full Service Wholesaler  Repackager  Own-Label Distributor  
 Private-Label Distributor  Chain Drug Warehouse  Other – **attach explanation of business**

Types of Drugs Distributed:  Non-Controlled Substances  Controlled Substances  
 OTC  Legend Medical Devices

Has the applicant, at any time, been convicted of any criminal offense under any federal, state or local law relating to wholesale or retail prescription drug distribution or distribution of controlled substances?  No  Yes, *attach a statement describing each criminal conviction, the date of conviction, and the jurisdiction in which the conviction occurred*

Has the applicant, at any time, been convicted of any felony criminal offense under any federal, state or local law?  No  Yes, *attach a statement describing each criminal conviction, the date of conviction, and the jurisdiction in which the conviction occurred*

Has the applicant, at any time, been subject to discipline by a regulatory agency in any state for violating any federal, state or local law relating to wholesale or retail prescription drug distribution or distribution of controlled substances?  No  Yes, *attach a statement describing each event of discipline, the nature of the discipline imposed, the date of discipline, and the regulatory agency imposing the discipline.*

**Trade Names used by applicant**

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

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

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

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

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

**List of Owners/Corporate Officers**

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

Position: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Position: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Position: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Position: \_\_\_\_\_ Phone: \_\_\_\_\_

## Licenses and permits held by applicant

<i><b>Federal DEA Information:</b></i>		
Registration Type	Registration #	
Issue Date	Expiration Date	
<b>State:</b>	<i><b>Issuing Agency:</b></i>	
License Type	License #	
Issue Date	Expiration Date	
<b>State:</b>	<i><b>Issuing Agency:</b></i>	
License Type	License #	
Issue Date	Expiration Date	
<b>State:</b>	<i><b>Issuing Agency:</b></i>	
License Type	License #	
Issue Date	Expiration Date	
<b>State:</b>	<i><b>Issuing Agency:</b></i>	
License Type	License #	
Issue Date	Expiration Date	
<b>State:</b>	<i><b>Issuing Agency:</b></i>	
License Type	License #	
Issue Date	Expiration Date	
<b>State:</b>	<i><b>Issuing Agency:</b></i>	
License Type	License #	
Issue Date	Expiration Date	

**(You may attach a list containing all requested licensure information)**

I, \_\_\_\_\_, the undersigned, am the individual with the applicant authorized to sign this application and swear this oath or make this affirmation or declaration on behalf of the applicant, and do hereby swear or affirm that the information contained in this application is true and correct.

\_\_\_\_\_  
Signature and Title of Applicant's  
Authorized Individual

\_\_\_\_\_  
Date

State of \_\_\_\_\_ )

County of \_\_\_\_\_ )

I, \_\_\_\_\_, a notary public, do hereby certify that on this \_\_\_\_\_ day of \_\_\_\_\_, 200\_, personally appeared before me \_\_\_\_\_, who, being by me first duly placed under oath, swore or affirmed that (he/she) is the (*title*) \_\_\_\_\_ of (*company*) \_\_\_\_\_, and that the information contained in said application is true and correct.

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

S E A L

My commission expires on \_\_\_\_\_, 20\_\_\_\_.



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## Instructions – Designated Representative

The following documents must be submitted with the Designated Representative Personal Information Statement:

- Question 2a and the identification of lawsuits against the business; you need only answer yes and provide information regarding those lawsuits against the business that **also involved your participation** in the same lawsuit as a named party or (regardless of whether or not you were a named party) as a witness at trial or as a witness in a deposition. Provide the name of the case, the court and jurisdiction in which the case was filed, and the nature of your involvement in that case, such as named party, trial witness and/or deposition witness.
- Employment Form: Was your position in a capacity related to the dispensing and distribution of, and recordkeeping relating to prescription drugs? ***If yes, list the total number of years and months in which you were employed in such capacity.*** (Board Rule 324.01.b requires a minimum 3 years experience in this area.)
- Photo of the Designated Representative taken within the previous year; passport photos are acceptable. ***No scanned photos will be accepted.***
- Finger Print card containing legible fingerprints of each of the digits on each of the Designated Representative's hands and properly completed by a law enforcement agency or approved vendor; submitted in sealed envelope. Prints will be submitted to Idaho State Police for FBI background check.

**Fingerprint cards must be submitted as per the protocols attached to the print cards. Print cards that are not properly sealed will be shredded.**

***In order to be processed the Designated Representative forms must be complete. If a question does not apply to applicant use N/A.***



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## Designated Representative Personal Information Statement

*~ Type or print clearly ~*

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

Previous name(s) or AKA: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN#: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Current Residence Address: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Email \_\_\_\_\_ Work Phone \_\_\_\_\_ Work Fax \_\_\_\_\_

1. Have you, during the last 7 years, been enjoined, either temporarily or permanently, by a court of competent jurisdiction from violating any federal or state law regulating the possession, control or distribution of prescription drugs or criminal violations?  
 No  Yes, *attach a statement setting forth the details of each event.*
  
2. Have you, in the last 7 years, been involved in any business, including any investments, other than ownership of stock in a publicly traded company or mutual fund, which manufactured, administered, prescribed, distributed or stored pharmaceutical products?  
 No  Yes, *complete Business Interest Form*
  - a. If yes, were there any lawsuits in which such business was named as a party **and** in which you were also a named party in the same lawsuit or, regardless of whether or not you were a named party, in which you testified as a witness at trial or in a deposition?  No  Yes, *attach a statement setting forth the name of the case, the court and jurisdiction in which the case was filed, and the nature of your involvement in the case.*
  
3. Have you, as an adult, been found guilty of any felony criminal offense, regardless of whether adjudication of guilt was withheld or whether you pled guilty or nolo contendere?  
 No  Yes, *attach a statement describing each felony conviction, the date of conviction, and the jurisdiction in which the conviction occurred*
  - a. Is any felony conviction presently under appeal?  No  Yes, *attach a copy of the notice of appeal of the felony conviction. You must within fifteen (15) days after the disposition of the appeal, submit to the Board of Pharmacy a copy of the final written order of disposition of your appeal.*

4. Have you been, in the last 7 years, the subject of any proceeding for the revocation of any license or any criminal proceeding?  No  Yes, *attach a statement setting forth the details of each event.*
5. Have you met the training requirements set forth in IDAPA 27.01.01.325.02  Yes  No
- ⇒ **02. Continuing Training for Designated Representative.** A licensed wholesale distributor’s designated representative must receive and complete: (4-2-08)
- ⇒ **b.** *If no formal continuing education is specified by the Idaho Board of Pharmacy, training programs that address applicable federal and state laws regarding wholesale distribution of prescription drugs and are provided by qualified in-house specialists, outside counsel, or consulting specialists with capabilities to help ensure compliance. (4-2-08)*
6. Complete the Residential Address form indicating your residences for the past seven (7) years. Make copies of the form as necessary.
7. Complete the Designated Representative Employment Form for each of your occupations, positions of employment and office held during the past seven (7) years. Make copies of the form as necessary.



## Residential Address past 7 years

~Type or print clearly~

### *Current Residential Address*

Address

City, St, Zip

Begin:            End:

### *previous Residential Address*

Address

City, St, Zip

Begin:            End:

### *previous Residential Address*

Address

City, St, Zip

Begin:            End:

### *previous Residential Address*

Address

City, St, Zip

Begin:            End:

### *previous Residential Address*

Address

City, St, Zip

Begin:            End:

## Designated Representative – Business Interest Form

*~ Type or print clearly ~*

<i>Business Interest – Begin:</i>		<i>end:</i>
Company		
Address		
City, St, Zip		
Phone		
Description of involvement:		
<i>Business Interest – Begin:</i>		<i>end:</i>
Company		
Address		
City, St, Zip		
Phone		
Description of involvement:		
<i>Business Interest – Begin:</i>		<i>end:</i>
Company		
Address		
City, St, Zip		
Phone		
Description of involvement:		

## Designated Representative - Employment Form

~ Type or print clearly ~

Past 7-year employment history, begin with current employment and explain any employment lapses

<i>Current Employment – Start date:</i>		<i>End Date:</i>	
Company			
Address			
City, St, Zip Phone			
Position or Title:			
Was/is your position in a capacity related to the dispensing and distribution of, and recordkeeping relating to prescription drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes, _____years _____months			
<i>previous Employment – Start date:</i>		<i>End Date:</i>	
Company			
Address			
City, St, Zip Phone			
Position or Title:			
Was/is your position in a capacity related to the dispensing and distribution of, and recordkeeping relating to prescription drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes, _____years _____months			
<i>previous Employment – Start date:</i>		<i>End Date:</i>	
Company			
Address			
City, St, Zip Phone			
Position or Title:			
Was/is your position in a capacity related to the dispensing and distribution of, and recordkeeping relating to prescription drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes, _____years _____months			

# Oath

I, \_\_\_\_\_, the undersigned, am the Designated Representative of \_\_\_\_\_ and swear this oath or make this affirmation or declaration on my own behalf, and do hereby swear or affirm that the information contained in this Personal Information Statement is true and correct.

\_\_\_\_\_  
Signature of Designated Representative

\_\_\_\_\_  
Date

State of \_\_\_\_\_)

County of \_\_\_\_\_)

I, \_\_\_\_\_, a notary public, do hereby certify that on this \_\_\_\_\_ day of \_\_\_\_\_, 200\_, personally appeared before me (*name*) \_\_\_\_\_, who, being by me first duly placed under oath, swore or affirmed that (he/she) is the Designated Representative of (*company*) \_\_\_\_\_, that he/she signed the foregoing Designated Representative Personal Information Sheet and that the information contained in said application is true and correct.

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

S E A L

My commission expires on \_\_\_\_\_, 20\_\_\_\_.