DC HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

RESIDENT PHARMACY RENEWAL LICENSE APPLICATION

Please type or print clearly in ink and in upper case letters only. Complete all sections and fields of the license application. Attach all documents and nonrefundable fee of $900, payable to DC Treasurer. Mail to: DC DOH – PHARMACY – P.O. BOX 37803, WASHINGTON, DC 20013.

INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.

REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at oig.dc.gov.

Applicant Info:

_____
Name of Pharmacy:

RX_____
Pharmacy License Number

Pharmacy Address:

_____ _____
Street Suite/Bldg./Floor

_____ _____ _____
City State Zip Code

Pharmacy Contact Info:

_____ _____
Pharmacy Contact Name Pharmacy Contact Email Address

_____
Pharmacy Contact Telephone Number

_____ _____
Pharmacy Email Address (if applicable) Pharmacy Website Address

Indicate type of pharmacy practice:

□ Community/Retail □ Nuclear □ Institutional □ Special/Limited Use

Indicate ownership type:

□Sole Proprietor □ Corporation □ Limited Liability □ Government Owned

Hours of Pharmacy Operation:

_____ _____ _____
Weekdays: Weekends: Holidays:

_____ _____
Name of Pharmacist-in-Charge (PIC) PIC Pharmacist Licenses

Affidavit

I certify that I have read and understand the pharmacy and drug laws and regulations of the District of Columbia, and I have made the pharmacy and drug laws and regulations of the District of Columbia available to all pharmacists working in the pharmacy.

_____ _____
Signature of Pharmacist-in-Charge Date

Answer the following questions by selecting "yes or no". Failure to respond to any question may result in delay in processing the application.

a) Does the pharmacy have the ability to provide the DC Department of Health (DC Health) with records of prescriptions dispensed to a District of Columbia resident no later than three (3) business days after the time DC Health requests the record?	☐**YES** ☐**NO**
b) Is the pharmacy in compliance with the confidentiality laws and regulations of the District of Columbia?	☐**YES** ☐**NO**
c) Does the pharmacy facilitate the dispensing, shipping, mailing, delivery, or distribution of prescription drugs or devices from any jurisdiction outside of the United States to District of Columbia residents?	☐**YES** ☐**NO**
d) Does the pharmacy engage in any forms of bulk compounding for District of Columbia residents?	☐**YES** ☐**NO**
e) Have any of the business' (owners or principal officers of the corporation, limited liability company or government entity) ever been convicted of a felony involving drugs?	☐**YES** ☐**NO**
f) Has the listed business or organization ever withdrawn an application (in the District of Columbia or any other state/jurisdiction)?	☐**YES** ☐**NO**
g) Has any authority or peer review board ever taken adverse action against the pharmacy's license or privileges?	☐**YES** ☐**NO**
h) Are any members of the business (sole proprietorship, corporation, limited liability company, or government entity) currently under investigation, or being investigated by any authority or peer review board for any violation of state, federal, or local law?	☐**YES** ☐**NO**
i) Has any authority or peer review board informed the business of any pending charge(s) or investigation not previously reported to the Pharmaceutical Control Division?	☐**YES** ☐**NO**
j) Has the application, corporation, association, partnership, or any other officer, partner, majority shareholder, or proprietor been convicted of a felony in connection with pharmaceuticals under District of Columbia, state, or federal law, or ever surrendered or had a pharmacy registration revoked, suspended, or denied?	☐**YES** ☐**NO**
k) I attest under perjury that this pharmacy is enrolled in and reports to the DC Prescription Drug Monitoring Program (PDMP) for the District of Columbia and/or has an approved reporting waiver on file with the District of Columbia PDMP program.	☐**YES** ☐**NO**
i) I certify that if this facility begins to dispense Controlled Substances (schedules II-V), cyclobenzaprine, or butalbital prescriptions, that quality for reporting under the provisions of the District of Columbia regulation 10302.1(a)(b), I will immediately notify the District of Columbia PDMP and will commence reporting immediately.	☐**YES** ☐**NO**
ii) DC Resident Agent Name: _____ Address: _____ _____	☐**YES** ☐**NO**

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District of Columbia Clean Hands

TO THE APPLICANT:
Please read carefully and completely before signing. A false statement on this certification requires that the Department proceed immediately to revoke the license or permit for which you are now applying and fine you $1,000. This certificate is required by the "CLEAN HANDS BEFORE RECEIVING A LICENSE OR PERMIT ACT OF 1996." (Effective May 11, 1996, D.C. Law 11-118, D.C. Code §47-2861 et seq.)

I, _____, certify that as of _____, I do not owe more
(PRINT NAME CLEARLY) (DATE)
than $100.00 to the District of Columbia government as a result of:

A. Fines, penalties or interest assessed pursuant to the Litter Control Administration Action of 1985, effective March 25, 1986 (D.C. Code § 6-2901 et seq.);
B. Fines, penalties or interest assessed pursuant to the Illegal Dumping Enforcement Act of 1994, effective May 20, 1994 (D.C. Law 10-117; D.C. Code § 6-2911 et seq.);
C. Fines, penalties or interest assessed pursuant to the Department of Consumer and Regulatory Affair Civil Infractions Act of 1985, effective October 5, 1986 (D.C. Law 6-42; D.C. Code § 6-2701 et seq.); or
D. Past due taxes. ☐**YES** ☐**NO**

The undersigned applicant understands that if he/she knowingly falsifies this Certification, the Department will move to revoke the license or permit for which he/she is applying, and to fine him/her $1,000.00. He/she further understand that the Department may conduct an investigation to ascertain the veracity of this certification. The undersigned applicant understands that this Certification is now required as documentation to accompany my application for a license or permit, and that by completing this Certification, he/she is not guaranteed that the license or permit will be approved. Please read carefully and completely before signing. A false statement on this certification requires that the Department proceed immediately to revoke the license or permit for which the undersigned applicant is now applying and fine him/her $1000.00. This certificate is required by the "CLEAN HANDS BEFORE RECEIVING A LICENSE OR PERMIT ACT OF 1996". (Effective May 11, 1996, D.C. Law 11-118, D.C. Code §47-2861 et seq.)

_____ _____
SIGNATURE OF APPLICANT DATE

IF THE RESPONSES TO QUESTIONS A AND K ARE "NO" OR IF ANY OF THE RESPONSES FOR QUESTIONS C, D, E, F, G, H, I, J, L ARE "YES," INCLUDE A SIGNED STATEMENT EXPLAINING THE RESPONSE. Refer to 22 DCMR Chapter 19 for further information.

In accordance with 22 DCMR §§1902.5 It shall be unlawful for any person to furnish false or fraudulent information on an application for a license or registration.

I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, ALL OF THE STATEMENTS MADE ARE TRUE, COMPLETE, AND CORRECT

Signature of Applicant: _____

Print Name and Tile: _____ Date: _____