

FOR OFFICIAL USE ONLY!

Application Complete:
 YES NO
Approved Registration:
 YES NO

FOR OFFICIAL USE ONLY!

DATE: _____
LIC/REG NO: _____
INITIALS: _____

Mail complete application and supporting documents to:
DC Health—Pharmacy
899 North Capitol Street NE, First Floor
Washington, DC 20002

PHARMACY LICENSURE APPLICATION

APPLICATION FEES ARE NON-REFUNDABLE

RETURN COMPLETED APPLICATION WITH REGISTRATION FEE MADE PAYABLE TO "D.C. TREASURER" TO 899 North Capitol Street NE, First Floor WASHINGTON, DC 20002
22 DCMR 1902.1 Licenses shall be issued for the following categories of pharmacies...except for nonresident pharmacies, which shall be required to register with the Department
22 DCMR 1902.2 A retail chain pharmacy with locations both in and outside of the District of Columbia (DC) shall obtain (a) a license for each location within DC and a registration pursuant of §1903 for each location outside DC

<p>CHECK ONE:</p> <p><input type="checkbox"/> Retail/Community Pharmacy <input type="checkbox"/> Nuclear Pharmacy <input type="checkbox"/> Institutional Pharmacy <input type="checkbox"/> Special or Limited Use Pharmacy <input type="checkbox"/> Nonresident Pharmacy</p>	<p>CHECK ONE: DC Resident Pharmacy (Biennial Licensing Fee: \$900) <input type="checkbox"/> Initial (Proposed date of opening _____) <input type="checkbox"/> Change of Ownership <input type="checkbox"/> Change of Pharmacy Name <input type="checkbox"/> Change of Pharmacy Location</p>	<p>CHECK ONE: Nonresident Pharmacy (Biennial Registration Fee: \$900) <input type="checkbox"/> Initial (Proposed date of opening _____) <input type="checkbox"/> Change of Ownership <input type="checkbox"/> Change of Pharmacy Name <input type="checkbox"/> Change of Pharmacy Location</p>
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I. Changes to Current Pharmacy Status
II pharmacies must report any change of ownership, name, location, or pharmacist-in-charge in writing to the Department

<p>CHANGE OF OWNERSHIP Proposed Effective Date: _____ Pharmacy License/Registration Number _____ Previous Owner Name _____ New Owner Name _____</p>	<p>CHANGE OF PHARMACY NAME Proposed Effective Date: _____ Pharmacy License/Registration Number _____ Previous Pharmacy Name _____ New Pharmacy Name _____</p>	<p>CHANGE OF PHARMACY LOCATION Proposed Effective Date: _____ Pharmacy License/Registration Number _____ Previous Pharmacy Address _____ New Pharmacy Address _____</p>	<p>PHARMACY CONTACT INFORMATION Representative Name _____ Phone _____ Email _____</p>
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II. District of Columbia Resident Pharmacy Only (Complete this section then go to page 3)

<p>Pharmacy Name _____</p> <p>Pharmacist-In-Charge (PIC) _____</p> <p>PIC License Number _____</p> <p>Signature of PIC _____</p>	<p>Pharmacy Street Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Certificate of Occupancy Number _____ (Please submit a copy of Certificate of Occupancy if this is an initial application)</p> <p>Current License Number, if applicable _____</p>	<p>Area Code and Telephone Number _____</p> <p>Area Code and Fax Number _____</p> <p>Expected Hours of Operation (Weekdays) _____</p> <p>Expected Hours of Operations (Weekends/Holidays) _____</p> <p>Email Address _____</p>
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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.