DC | HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

FOR OFFICIAL USE ONLY!	FOR OFFICIAL USE ONLY!
Application Complete:	
□ YES □ NO	DATE: _____
Approved Registration:	LIC/REG NO: _____
□ YES □ NO	INITIALS: _____

Mail complete application and supporting documents to:
DC Health—Pharmacy
899 North Capitol Street NE, First Floor
Washington, DC 20013

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

CHECK ONE:	***CHECK ONE:***	***CHECK ONE:***
☐ Retail/Community Pharmacy	**DC Resident Pharmacy**	**Nonresident Pharmacy**
☐ Nuclear Pharmacy	(Biennial Licensing Fee: $900)	(Biennial Registration Fee: $900)
☐ Institutional Pharmacy	☐ Initial (Proposed date of opening _____	☐ Initial (Proposed date of opening _____
☐ Special or Limited Use Pharmacy	☐ Change of Ownership	☐ Change of Ownership
☐ Nonresident Pharmacy	☐ Change of Pharmacy Name	☐ Change of Pharmacy Name
	☐ Change of Pharmacy Location	☐ Change of Pharmacy Location

I. Changes to Current Pharmacy Status

All pharmacies must report any change of ownership, name, location, or pharmacist-in-charge in writing to the Department

CHANGE OF OWNERSHIP	CHANGE OF PHARMACY NAME	CHANGE OF PHARMACY LOCATION	PHARMACY CONTACT INFORMATION
Proposed Effective Date:_____	Proposed Effective Date:_____	Proposed Effective Date:_____	
Pharmacy License/Registration Number	Pharmacy License/Registration Number	Pharmacy License/Registration Number	Representative Name _____
Previous Owner Name	Previous Pharmacy Name	Previous Pharmacy Address	Phone _____
New Owner Name	New Pharmacy Name	New Pharmacy Address	Email _____

II. District of Columbia Resident Pharmacy Only *(Complete this section then go to page 3)*

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

III. Nonresident Pharmacy Only

Pharmacy Name

Pharmacy Street Address

City **State** **Zip**

Area Code and Telephone Number

Area Code and Fax Number

Toll-Free Telephone Number for Consultation

Email address

Pharmacist-in-Charge (PIC)

PIC Pharmacy License Number **State of Licensure**
(Submit copy of PIC pharmacy license)

Affidavit
I certify that I have read and understand the pharmacy and drug laws and regulations of DC, and I have made the pharmacy and drug laws and regulations of DC available to all pharmacists working in the nonresident pharmacy

Pharmacist-in-Charge Signature

Date

PLEASE WRITE THE REQUESTED INFORM ATION AND SUBMIT LEGIBLE COPIES OF THE FOLLOWING:

☐ **Certificate of Occupancy Number:**

☐ **Pharmacy License Number in resident state:**

☐ **DEA Registration Number:**

☐ **Most recent pharmacy inspection report:**

Please write pharmacy mailing address, if applicable:

22 DCMR 1903.8(d)(4) List of Pharmacists practicing at this pharmacy
check here if list is attached to the application

Pharmacist Name	License Number

22 DCMR 1903.8(d)(5) List of resident agents located within DC designated to accept service of process
check here if list is attached to the application

Name **Title**

Address

Name **Title**

Address

Name **Title**

Address

22 DCMR 1903.8(h) List of website address(es), domain registration(s), and pharmacy email address(es).
check here if list is attached to the application

IIIa. Please Answer the Following Questions

1. Is the nonresident pharmacy's license, registration, or permit in good standing in the state which it is located? ☐ YES ☐ NO

2. Does the nonresident pharmacy have the ability to provide to the DC Health a record of prescription orders dispensed to a DC resident no later than three (3) business days after the time the Department requests the record? ☐ YES ☐ NO

3. Is the nonresident pharmacy solely internet-based or operates primarily as an internet-based pharmacy? ☐ YES ☐ NO
If "YES", please submit proof of:
   Certification by the Verified Internet Pharmacy Practice Site Program of the National Association of Boards of Pharmacy, or other national certification program for internet pharmacies for each website and domain registration
   Proof of registration in good standing in DC as a foreign corporation

4. Does the nonresident pharmacy have a toll-free telephone number disclosed on a label affixed to each container of drugs or medical devices dispensed to patients in DC? **PLEASE SUBMIT A COPY OF THE LABEL SHOWING THE TOLL-FREE NUMBER** ☐ YES ☐ NO

5. Is the nonresident pharmacy in compliance with the laws and regulations regarding confidentiality of prescription records in the state in which it is located, and if there are no such laws in that state, then is the pharmacy in compliance with the confidentiality laws and regulations of DC? ☐ YES ☐ NO

IV. Proprietor Information

Proprietor Type (CHECK ONE) _INDIVIDUAL _CORPORATION _PARTNERSHIP _UNINCORPORATED INDIVIDUAL _OTHER:

Name of Individual, Corporation, Partnership, Other **Billing Street Address** **City** **State** **Zip** Is the corporation in good standing with DC or the state of incorporation? ☐YES ☐NO Has any principal corporate officer ever been convicted of a felony involving drugs? ☐YES ☐NO *If the answer to this is "YES", please submit a statement of explanation with this application*	**NAME AND ADDRESS FOR PRINCIPAL OFFICERS** **President of Corporation/Partnership** **Vice President of Corporation/Partnership** **Secretary of Corporation/Partnership**	**Treasurer of Corporation/Partnership** **Other Principal Corporate Officer** **State of Incorporation** **Year Incorporated**

V. Please Answer the Following Questions

1. Does your pharmacy facilitate the dispensing, shipping, mailing, delivery, or distribution of prescription drugs or devices from any jurisdiction outside of the United States to DC residents? ☐YES ☐NO *If the answer to this is "YES", please submit a statement of explanation with this application*
2. Did you include your licensing/registration fee? ☐YES ☐NO
3. Did you include copies of all required documents? ☐YES ☐NO

VI. Certification Form

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 $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.)

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

1. 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.);
2. 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.);
3. 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
4. Past due taxes.

I understand that if I knowingly falsify this Certification, the Department will move to revoke the license or permit for which I am applying, and to fine me $1,000.00. I further understand that the Department may conduct an investigation to ascertain the veracity of this certification. I understand that this Certification is now required as documentation to accompany my application for a license or permit, and that by completing this Certification, I am not guaranteed that my license or permit will be approved.

_____. _____.
Signature of Applicant Title

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 of Applicant Date

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.