

Return Application With
Check Payable To:
NH Board of Pharmacy
Annual Fee: \$250

State of New Hampshire
Board of Pharmacy
57 Regional Drive
Concord, NH 03301-8518
Tel.: (603) 271-2350 Fax: (603) 271-2856
Website: www.nh.gov/pharmacy/

Board Use Only (Do Not Write In This Box)

Check #: _____

**MANUFACTURER, WHOLESALER / DISTRIBUTOR,
OR BROKER OF PRESCRIPTION DRUGS AND/OR DEVICES**
FOR SALE OF PRODUCTS AT WHOLESALE ONLY

APPLICATION FOR PERMIT TO CONDUCT BUSINESS IN THE STATE OF NEW HAMPSHIRE
July 1, 2011 – June 30, 2012 Licensing Period

Check here if this application is being submitted as part of a *change of ownership* for a current NH registered mail-order pharmacy. If so, enter current NH License # _____

Location Of Facility Where Actual Manufacturing / Distribution Takes Place (If Broker Only, Business Mailing Address):

Company Name _____

Street Address _____

City _____ State _____ Zip Code _____

Parent Company (If None, Write "None"): _____ State Of Incorporation (If Corp.): _____

Nature Of Business (Check ALL That Apply): <input type="checkbox"/> Manufacturer <input type="checkbox"/> Wholesaler/Distributor <input type="checkbox"/> Broker <input type="checkbox"/> Other (Attach Detailed Explanation of Nature of Business)	Doing Business As: <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> LLC
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Telephone: _____	E-Mail Address (Contact Person for Board Inquiries Regarding Application): _____
DEA Number (If Shipping Controlled Drugs): *Attach Copy Of Permit With Application	State Controlled Substance Lic. #: If Applicable: *Attach Copy Of Permit With Application

Name Of Owner(s): Indicate Individual, Partners, Etc. (If Corporation, Show Title Of Officers). Attach Additional Sheet If Necessary.

Name _____	Address _____	Title _____
Name _____	Address _____	Title _____
Name _____	Address _____	Title _____
Name _____	Address _____	Title _____

Is the above referenced company (physical location) licensed by the board of pharmacy in the state of location?
 Yes * No * *(If "yes", attach a copy of the state license/permit & the most recent inspection. If No, attach letter explaining why licensure is not required in home state – a letter from home-state's Board of Pharmacy is preferred).

In the past 3-years has the registration or licensure granted to the above referenced company been suspended, revoked, or otherwise disciplined by any state or federal agency? Yes * No *(If "Yes", attach a detailed explanation)

DO NOT LEAVE ANY BLANK SPACES – IF NOT APPLICABLE, WRITE 'N/A' & THE REASON IT DOES NOT APPLY

APPLICATION CONTINUED ON NEXT PAGE ↪

Provide the name, address, & title of the person to whom the permit and/or renewal application should be directed:

Name:	Title:	Tel. #:
Business Mailing Address:		

If shipping controlled drugs, provide the name, address, telephone & fax # of the person to whom communication regarding controlled substance distribution records may be directed:

Name:	Telephone #:	Fax #:
Business Mailing Address:		

Which of the following entities do you sell / ship to?

- | | | | |
|--|--|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Retail Pharmacies | <input type="checkbox"/> Hospital Pharmacies | <input type="checkbox"/> Physicians | <input type="checkbox"/> Dentists |
| <input type="checkbox"/> Veterinarians | <input type="checkbox"/> Other Wholesalers | <input type="checkbox"/> Other _____ | |

Categories of product being sold / shipped into New Hampshire at wholesale?

- | | | |
|---|---|--|
| <input type="checkbox"/> Controlled Substances | <input type="checkbox"/> Human Prescription Drugs | <input type="checkbox"/> Veterinary Prescription Drugs |
| <input type="checkbox"/> Prescription Devices(At Wholesale) | <input type="checkbox"/> Medical Gases (At Wholesale) | <input type="checkbox"/> Other _____ |

Declaration And Signature Of Company Representative:

I have attached the following required documents:

- A copy of the state license from the state licensing agency where the facility is located.
- A copy of the facility's DEA Registration (if manufacturing and/or distributing controlled drugs).
- A copy of the facility's most recent inspection report completed by the state licensing board/agency where the facility is located or by the federal FDA or DEA. *If not included, a detailed description as to why this is not available must be attached to this form.*
- A chart / diagram showing level / percentages of ownership (corporate organizational chart).

I affirm that I am the person authorized to sign this application for licensure and declare under penalties of perjury that this application (including any accompanying documents) has been examined by me and to the best of my knowledge and belief is a true, correct and complete application, and if the registration herein applied for is granted, I hereby agree to and do submit to the jurisdiction of the New Hampshire Board of Pharmacy and to the laws and rules of this State. My signature below also affirms that I have reviewed the laws/rules regarding prescription drug/device manufacturers/wholesalers/distributors found at <http://www.nh.gov/pharmacy/mftinfo.html> (or available in print form upon request) and agree to abide by those regulations.

Signature: _____ Title: _____ Date: _____

INCOMPLETE APPLICATIONS OR APPLICATIONS WITHOUT REQUIRED ATTACHMENTS WILL NOT BE ACCEPTED.

DO NOT LEAVE ANY BLANK SPACES – IF NOT APPLICABLE, WRITE N/A & THE REASON IT DOES NOT APPLY SO WE KNOW YOU DID NOT MISS A QUESTION.

ANY SUBSEQUENT CHANGES TO THE INFORMATION ON THIS FORM MUST BE REPORTED TO THE BOARD IN WRITING WITHIN 30 DAYS.