M/W INFORMATION FORM

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
New York State Board of Pharmacy
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Albany, NY 12234-1000
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Lawrence H. Mokhiber
Executive Secretary

REGISTRATION NUMBER: ______________________

PART I (Print in Black Ink)

(check one): ☐ **Manufacturer** ☐ **Repacker of Drugs** ☐ **Repacker of Medical Gases** ☐ **Wholesaler**

1 **Name of owner/corporation under which registration has been issued or is sought:**

2 **Trade Name (if applicable):**

3 **M/W Address:**

Street and Number

City

State County

Zip Code

4 **Complete ONE of the Following:**

A. ☐ **New Registration** **Proposed date of opening:** mo . day yr.

B. ☐ **Transfer of Ownership** **Proposed date of transfer:** mo . day yr.

Name of previous registrant: ______________________________

Registration number:

C. ☐ **Change of location** **Proposed Date of change:** mo . day yr.

Previous address: ______________________________

D. ☐ **Renovation** **Proposed date of renovation:** mo . day yr.

E. ☐ **Update/Other** ______________________________

5 **Has the applicant applied for or been issued registration at any other location in this state by this department?** ☐ **Yes** ☐ **No**

If yes, please list the address and registration number. Use additional paper if necessary.

______________________________ ______________________________
Location and Address Registration Number

Does this applicant have a New York State registered pharmacy? ☐ Yes ☐ No

6 **List Supervisor of this establishment**

____

7 **A. Nature of registration:**

- ☐ Manufacturer/wholesaler ☐ Yes ☐ No
- ☐ Wholesaler only ☐ Yes ☐ No
- ☐ Repacker/wholesaler ☐ Yes ☐ No
- ☐ Medical gas repackager ☐ Yes ☐ No

B. Daily schedule of hours the establishment will be opened. (list days of week and hours opened.)

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C. List percent of business done with the following (must equal 100%):

Domestic __________ % Foreign __________ %

8 **Check ALL items distributed at this location.**

- ☐ Prescription required drugs (human)
- ☐ Medical Devices
- ☐ Prescription required drugs (animal)
- ☐ Hypodermic syringes and needles
- ☐ Controlled substances
- ☐ Compressed medical gases/liquid
- ☐ Over the counter drugs
- ☐ Cosmetics
- ☐ Other ____

9 **Building/Space Requirements**

Has the following been adequately provided for? (check yes or no)

Item	Yes	No
Adequate lighting	☐ Yes	☐ No
Appropriate sanitation	☐ Yes	☐ No
Adequate space	☐ Yes	☐ No
Necessary equipment	☐ Yes	☐ No
Appropriate security	☐ Yes	☐ No
Secure quarantine area	☐ Yes	☐ No
Orderly stock control	☐ Yes	☐ No
Free from insects, rodents, birds or vermin	☐ Yes	☐ No
Drug areas secure from unauthorized entry	☐ Yes	☐ No
Outside access well controlled and kept to a minimum	☐ Yes	☐ No
Outside perimeter well lighted	☐ Yes	☐ No
Alarm system for after hours	☐ Yes	☐ No
Security system against theft and diversion	☐ Yes	☐ No
Computer and electronic system security against theft and diversion	☐ Yes	☐ No
Temperature control	☐ Yes	☐ No
Humidity control	☐ Yes	☐ No
Written policies and procedures for distribution/recalls etc.	☐ Yes	☐ No
Hot and cold running water	☐ Yes	☐ No

Recording equipment used for temperature/humidity (check each):

Item	Yes	No
Manual	☐ Yes	☐ No
Electromagnetic	☐ Yes	☐ No
Electronic	☐ Yes	☐ No

Neighborhood (check type):

Item	Yes	No
Commercial	☐ Yes	☐ No
Residential	☐ Yes	☐ No
Both	☐ Yes	☐ No

Pharmacy Guide to Practice, Reference books, etc. ☐ Yes ☐ No

FOR MANUFACTURERS AND REPACKERS ONLY

10 **Supervision**

Will all manufacturing and/or repacking be done under the personal supervision of a licensed pharmacist? ☐ Yes ☐ No

Supervisor's who are not pharmacists shall meet the requirements as outlined in Section 63.6 (c)(1) of the regulations for registration and operation and of the establishments.

11 Do you have storage or manufacturing facilities for drug products at an address other than that indicated? ☐ Yes ☐ No

If your answer is "Yes," indicated locations and explain:

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PART II

- Draw to scale the proposed establishment, indicating all dimensions. Show all doors and walls.
- Indicate areas for storage of drugs (drug bays).
- In red pen, indicate **R for refrigerator.**
- In red pen indicate **S for sink** that is located in the compounding and dispensing area.
- Outline the registered area in yellow.
- Indicate the premises adjacent to the buildings, offices and public thoroughfares.
- Name the adjacent businesses.
- **DO NOT SEND A BLUEPRINT, IT WILL BE DISCARDED.**

1	**Total registered area ____________________ sq. ft.**
2	**Indicate Scale _________________________ sq. ft.**

PART III

Contact person to clarify information provided on this application:

Name: ____

Phone: ____

Fax: ____

Email address: ____

PART IV: ATTESTATION

I affirm that all information submitted to the Board of Pharmacy is true. I am familiar with the Pharmacy Guide to Practice and the laws which govern the distribution of drugs and/or devices in New York State and with the Title 21 Code of Federal Regulations Part 205. I further understand that manufacturers, repackers and wholesalers may only sell drugs and/or devices to those purchasers authorized by law to receive them, and that records of the receipt and disposition of all drugs and/or devices shall be maintained for a period of five years and shall be available to the Department or any other authorized State or Federal agency for a period of not less than five years.

____ ________________________
*Signature of applicant (Individual owner, partner, corporate officer, or *other authorized person)* *Date*

____ ________________________
Print Name *Date*

*Power of attorney must be submitted for “other authorized person”

PART V: INSPECTION

Investigator’s Comments:

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____ ________________________
Signature – Investigator Office of Professional Discipline *Date*

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Print name