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Arizona State Board of Pharmacy

APPLICATION FOR DRUG WHOLESALE PERMIT

(Call Board Office for Fee Information)

***Please check appropriate type of operation*: Full Service ____ Non-prescription ____**

1. Business name:____
2. Address:____
   Street and Number City State Zip
3. Phone:____________ FAX:____________ E-mail____________
4. Mailing address if different:____
   Street and Number City State Zip
5. Name of owner(s):____________________ Phone:__________ FAX:__________
   If corporation or partnership, attach a list of officers or partners on a separate sheet, including name, title and address.
6. Date business started/opening:____
7. This application submitted because of change in ownership? No___. Yes___. If yes; give former owner's name, AZ permit number, and permit name (if different)____
8. Other trade or business names used:____
9. Have you conducted a similar business in any other jurisdiction?
   No___. Yes___. If yes, state under what names and locations.

   ____
10. Has the owner, or any corporate officer or active partner ever been convicted of an offense involving moral turpitude, a felony offense, or any drug-related offense or has any currently pending felony or drug-related charges, and is so indicate charge, conviction date, jurisdiction, and location:

    ____
11. Has the owner, any corporate officer or active partner ever been denied a wholesale drug permit in this state or any other jurisdiction?
    No___. Yes___. If yes, indicate where and when:

    ____
12. Check types of drugs to be distributed/stocked:
    Nonprescription___. Prescription only___. Controlled substances___. Human or Veterinary___.
13. FACILITIES LOCATED IN ARIZONA the following is required:
    a) Floor plan. Include plans or construction drawing showing facility size and security adequate for the proposed business.
    b) Zoning. Include documentation of compliance with local zoning laws.
    c) The person named in Number 15 will be present at the Arizona State Board of Pharmacy meeting when application is submitted for approval.
14. FACILITIES LOCATED OUTSIDE OF ARIZONA: Attach a photo copy of license/permit issued by State of domicile.
15. Name of designated representative (manager) : ____________________ Emergency phone:____________
16. **If Full Service provide a resume indicating educational or experiential qualifications related to drug wholesale operations as required by ARS § 32-1982(B) and provide evidence of bond required by ARS. § 32-1982 (D). (please attach to this application)**

To the best of my knowledge and belief the foregoing application is true and current in all respects.

____________________ ____________ ____________

Signature of Owner, Corporate Officer of Manager Title Date