

APPLICATION FOR REGISTRATION

NONPRESCRIPTION DRUG OUTLET

(Expires January 31 Annually)

OREGON BOARD OF PHARMACY
800 NE OREGON ST, SUITE 150
PORTLAND, OR 97232
TELEPHONE (971) 673-0001
www.pharmacy.state.or.us



FOR BOARD USE ONLY	[0302] \$50.00
RECEIPT #	_____
CHECK #	_____
ENTERED BY	_____

NONPRESCRIPTION DRUG OUTLET

FEE: \$50.00

ALL FEES ARE NON-REFUNDABLE

The Nonprescription Drug Outlet Registrations are broken into two categories: those that stock six or fewer items and those that stock seven or more items. Each different "over-the-counter medication" contained in a single package is identified as one item, regardless of package size, drug strength or manufacturer. (Tylenol, Tylenol Extra Strength, Advil and Aspirin each contain one item. Tylenol PM contains two items.) Please note that the application fee for each category (Class A and Class B) is \$50.00.

Class A Grocery Store, Convenience Store, Department Store. Our business will stock seven or more items. **Class B** Candy Counter, Gift Shop, Tavern, etc. Our business will stock six or fewer items.

New Outlet Start Date _____
 Owner Change Date Effective _____ Former license number _____
 Location Change Date Effective _____ Former license number _____

A change of ownership or location **requires** the submission of a new application and registration fee within 15 days. Please check the appropriate box regarding application status: Name change only – (no fee required)

Please PRINT or TYPE **WARNING:** ORS 475.135 (e) The furnishing of false information is grounds to deny registration.

Business Name _____
 Location Address _____
 Phone Number () - FAX # () -
 City, State, Zip _____
 License & Renewal Mailing Address _____
 City, State, Zip _____
 Contact Person _____ Title _____ Contact Phone _____
 Phone Number () - FAX # () -
 Federal Tax ID # or Owner SSN: _____ Does this outlet belong to a chain? Yes No

Business Ownership: *If owned by a corporation, please complete line 4 below:

- Corporation or LLC (Name and address of corporation officers or members.) Individual Owner, Trustee or Receiver. (Enter name, title & address below.) Partnership (List below names and addresses of the 3 largest share holders.)

NAME	TITLE	MAILING ADDRESS & PHONE
1.		
2.		
*Corporate/LLC Name	*Date Organized (if new)	State in which incorporated

PLEASE CHECK ONE:

- I wish to have my registration application processed on the date you receive my COMPLETE APPLICATION and PAYMENT in your office. Because the Oregon Board of Pharmacy does not prorate fees, **I realize that by having my registration become effective before the beginning of the renewal period (February 1) my license will not be valid for a full year.**
- I wish to have my registration become effective on the following February 1st. I realize that I cannot sell any over the counter medications until then. (**ONLY APPLICABLE FOR NEW OUTLETS*)

Signature _____ Title _____ Date _____

MAIL THIS APPLICATION WITH \$50 FEE, PAYABLE TO THE OREGON BOARD OF PHARMACY.
 ALL RETURNED CHECKS WILL BE ASSESSED A \$35.00 RETURNED CHECK FEE PURSUANT TO ORS 30.701(5)