# PHARMACY APPLICATION

| | | |
|---|---|---|
| Customer Name | | |
| DBA | | |
| Street Address | | |
| City / State / Zip | | |
| Phone Number: | | Fax Number: |
| Email Address(es): | | |

## *LICENSE INFORMATION - INCLUDE COPY OF EACH WITH APPLICATION*

| | |
|---|---|
| DEA License #: | State License #: |
| DEA Expiration Date: | State Expiration Date: |
| Pharmacy NCPDP #: | Tax ID #: |
| Pharmacist Name & License Number: | |

## *OWNERSHIP INFORMATION*

| | |
|---|---|
| **Ownership Type:** | ____ Corporation ____ Sole Proprietor<br>____ Partnership ____ Other (explain) _____ |
| **Business Type:** | ____ Retail Pharmacy ____ Apothecary<br>____ Closed Door Pharmacy ____ Long Term Care<br>____ Compounding Pharmacy ____ Pharmacy within a hospital, clinic or medical center<br>____ Mail Order Pharmacy<br>____ Other (explain) _____ |
| Owner(s) Names: | |
| Owner's DBA, if any: | |
| Owner's Business Address: | |
| Owner's Phone #: | Fax #: |
| Owner's Email: | |
| Number of Years Owner has Operated Pharmacy: _____ | |

## *BUSINESS INFORMATION*

| | | | |
|---|---|---|---|
| **Number of prescription filled:** Daily: Monthly: | | | |
| **What is the current ratio of controlled substance orders vs non-controlled orders: _____** | | | |
| **List of Suppliers you have used within the last 24 months:** | | | |
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| | | | |
| | | | |
| **Which Suppliers will you continue to do business with:** | | | |
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