

## NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Parkway, Suite 206 - Reno, NV 89521 - (775) 850-1440

### Wholesaler Application

**Non-Refundable \$1,000 Fee**

Rev (08/17/2022)

**This application cannot be returned by fax or email.  
We must have an original signature and fee to process.**

**NRS 639.016 “Wholesaler” defined.** “Wholesaler” means a wholesale distributor as defined by 21 C.F.R. § 205.3(g) who supplies or distributes drugs, medicines or chemicals or devices or appliances that are restricted by federal law to sale by or on the order of a physician to a person other than the consumer or patient. The term includes a person who derives, produces, prepares or repackages drugs, medicines or chemicals or devices or appliances that are restricted by federal law to sale by or on the order of a physician on sales orders for resale. The term does not include a nonprofit cooperative agricultural organization which supplies or distributes veterinary drugs and medicines only to its own members.

**NRS 639.009 “Manufacturer” defined.** “Manufacturer” means a person who:

1. Derives, produces, prepares, compounds, mixes, cultivates, grows or processes any drug or medicine;
2. Repackages any drug or medicine for the purposes of resale; or
3. Produces or makes any devices or appliances that are restricted by federal law to sale by or on the order of a physician.

Print and mail the completed application with a **non-refundable fee** of \$1,000.00 paid for by credit or debit card or a check made payable to the **Nevada State Board of Pharmacy**. Credit and debit card payments are charged a **5% processing fee**. Send the completed application to the address indicated on top of this application.

All incomplete applications will be returned. Please ensure all requirements of the application are completed before submission. The deadline date for an application to be considered during a particular board meeting is posted on our website. If a completed application is not received by our office by the deadline, the application will not be considered until the next scheduled board meeting. **Please note that an application received just prior to the deadline date does not guarantee placement on the board agenda.** Upon receipt of a completed application, the application will be placed on the agenda of the next regularly scheduled Board meeting. For application deadlines and meeting schedule please visit [bop.nv.gov](http://bop.nv.gov).

If you have any questions, please contact the Nevada State Board of Pharmacy at 775-850-1440.

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<b>Where is the facility located?</b>		<input type="checkbox"/> Nevada <input type="checkbox"/> Out-of-State
<b>Type of Application (check applicable box)</b>		<b>Wholesaler Business Type (check applicable box)</b>
<input type="checkbox"/> New Wholesaler <input type="checkbox"/> Ownership Change* <input type="checkbox"/> Name Change* <input type="checkbox"/> Location Change* (in-state only)	* If making a change, provide current license number: WH _____	<input type="checkbox"/> Publicly Traded (complete sections 1, 2, 3, 4, 8, 9) <input type="checkbox"/> Non-Publicly Traded (complete sections 1, 2, 3, 5, 8, 9) <input type="checkbox"/> Partnership (complete sections 1, 2, 3, 6, 8, 9) <input type="checkbox"/> Sole Owner (complete sections 1, 2, 3, 7, 8, 9)

<b>Section 1: General Information</b>		
Facility Name: _____		
Physical Address: _____		
City: _____	State: _____	Zip: _____
Mailing Address (if different from physical address): _____		
City: _____	State: _____	Zip: _____
Telephone: _____	Website: _____	
Name of Designated Representative (DR): _____		
Licensing Company Email: _____	DR Email: _____	

Entities the Wholesaler will Serve (✓ all applicable)	Products to be Handled or Wholesaled (✓ all applicable)	Type of Wholesaling (✓ all applicable)
<input type="checkbox"/> Pharmacies <input type="checkbox"/> Practitioners <input type="checkbox"/> Hospitals <input type="checkbox"/> Wholesalers <input type="checkbox"/> Veterinarians <input type="checkbox"/> Others:	<input type="checkbox"/> Dangerous Drugs <input type="checkbox"/> Controlled Substances <input type="checkbox"/> <sup>a</sup> Medical devices, equipment, supplies, gases <input type="checkbox"/> Others:	<input type="checkbox"/> Manufacturer <input type="checkbox"/> Repacker <input type="checkbox"/> Reverse Distributor <input type="checkbox"/> Warehouse <input type="checkbox"/> Retail pharmacy wholesale distributor <input type="checkbox"/> Others:

Section 2: History of Company	Yes	No
1. Has the corporation, any owner(s), shareholder(s) or partner(s) with at least 10% interest or partners with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)?		
2. Has the corporation, any owner(s), shareholder(s) or partner(s) with at least 10% interest or partners with any interest, ever been denied a license, permit or certificate of registration?		
3. Has the corporation, any owner(s), shareholder(s) or partner(s) with at least 10% interest or partners with any interest, ever been subject of an administrative action or proceeding relating to the pharmaceutical industry?		
4. Has the corporation, any owner(s), shareholder(s) or partner(s) with at least 10% interest or partners with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances?		
5. Has the corporation, any owner(s), shareholder(s) or partner(s) with at least 10% interest or partners with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)?		

Please use and make copies of this page (if necessary) to provide information regarding any questions, 1-5, you have marked “YES” to in section 2 of the application. A signed statement of explanation for each event and a copy of all documents that identify the circumstance or contain an order, agreement or other disposition for the event must be provided.

This is in response to Question # \_\_\_\_\_. Provide all the following *where applicable*:

Date of Event/Arrest	Disposition Date	State	City	County
Case #		Governing, licensing, Arresting Presiding Body/Agency/Court		
Reason/Charge				
Plaintiff/Defendant/Claimant/Respondent			Lawsuit/Arbitration/Bankruptcy	
Name of Business/Industry/Entity				

Provide explanation below:

\_\_\_\_\_  
Original Signature (electronic, copies or stamps not accepted)

\_\_\_\_\_  
Date

**Section 3: List the top four suppliers your company has been associated with in regards to pharmaceutical products that were sold, dispensed or distributed within the last year.**

Name: _____	City: _____	State: _____	Zip: _____
Address: _____			
Name: _____	City: _____	State: _____	Zip: _____
Address: _____			
Name: _____	City: _____	State: _____	Zip: _____
Address: _____			
Name: _____	City: _____	State: _____	Zip: _____
Address: _____			

**Section 4: Publicly Traded Corporation**

State of Incorporation: \_\_\_\_\_

Parent Company (if any): \_\_\_\_\_

Corporation Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Contact Person Name: \_\_\_\_\_

Date of SEC Registration: _____	SEC Registration Number: _____	Stock Exchange Symbol: _____
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**Section 5: Non-Publicly Traded Corporation or Company**

State of Incorporation/Organization: \_\_\_\_\_

Parent Company (if any): \_\_\_\_\_

Corporation/Organization Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Contact Person Name: \_\_\_\_\_

**Section 6: Partnership**

Partnership Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Contact Person Name: \_\_\_\_\_

**Section 7: Sole Owner**

Owner's Name: \_\_\_\_\_

Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Section 8: NABP Accreditation/FDA Registration	Yes	No
Is your company Drug Distributor or VAWD Accredited by NABP? If yes, provide:		
1. Copy of Certification 2. Copy of a bond in an amount of \$25,000 made payable to the state of Nevada. This must be current to maintain a Nevada wholesaler registration. Complete the <b>Surety Bond form</b> at <a href="http://bop.nv.gov/Services/newapps/Business/">http://bop.nv.gov/Services/newapps/Business/</a> .		
Is your company licensed as a Manufacturer by the FDA? If yes, provide:		
1. Copy of FDA registration 2. Copy of a bond in an amount of \$25,000 made payable to the state of Nevada. This must be current to maintain a Nevada wholesaler registration. Complete the <b>Surety Bond form</b> at <a href="http://bop.nv.gov/Services/newapps/Business/">http://bop.nv.gov/Services/newapps/Business/</a> .		

Section 9: Provide the following documents with your application based on your Business Type. Required documents are indicated by an "✓" on the right.	Publicly Traded	Non-publicly Traded	Partner-ship	Sole Owner
• List of <u>all</u> Officers and Directors.	✓	✓		
• List the <u>top four</u> corporation shareholders and their percent ownership.	✓			
• List of <u>all</u> corporation shareholders and their percent ownership.		✓		
• List of <u>all</u> partners and their percent ownership.			✓	
• Certificate of Corporate Status or Certificate of Good Standing obtained from the Secretary of State's Office in the State where the business is domiciled, dated within the last <b>12 months</b> .	✓	✓	✓	✓
• Designated Representative form must be completed by the Designated Representative. Access form at <a href="http://bop.nv.gov/Services/newapps/Business/">http://bop.nv.gov/Services/newapps/Business/</a>		✓	✓	✓
• Personal History Record Application must be completed by each shareholder/stockholder/partner/owner owning more than 10% of the business stocks/shares. Access form at <a href="http://bop.nv.gov/Services/newapps/Business/">http://bop.nv.gov/Services/newapps/Business/</a>		✓	✓	✓
• Copy of DEA certificate if handling controlled substances	✓	✓	✓	✓
• Copy of current SEC 10K or 8K (First 15 pages only)	✓			
• List containing each employee, agent, independent contractor, consultant, guardian, personal representative, lender or holder of indebtedness of the applicant.	✓	✓	✓	✓
• Copy of your license, certification, permit or registration issued to your wholesaler business from the regulatory board or licensing authority of the state or territory in which the wholesaler is located. (REQUIRED FOR OUT-OF-STATE WHOLESALERS, if applicable)	✓	✓	✓	✓
• <sup>a</sup> Medical Devices, Equipment and Gases (MDEG) Administrator form must be completed if the business will wholesale medical devices, equipment, supplies, gases, including hypodermic devices. (NAC 639.6957). Access form at <a href="https://bop.nv.gov/Services/newapps/Business/">https://bop.nv.gov/Services/newapps/Business/</a>	✓	✓	✓	✓
• If providing <sup>a</sup> Medical Devices, Equipment and Gases (MDEG), supply a copy of proof of insurance (NAC 639.6957). The MDEG wholesaler shall maintain liability insurance of at least one million dollars (\$1,000,000.00).	✓	✓	✓	✓
<b>ONLY Complete below if your company is NOT accredited by NABP and/or FDA registered (see Section 8)</b>				
• Submit Fingerprints following instructions found at: <a href="http://bop.nv.gov/uploadedFiles/bopnv.gov/content/Services/newapps/Fingerprint%20Submission%20Instructions%20-%20Effective%2001.01.2024.pdf">http://bop.nv.gov/uploadedFiles/bopnv.gov/content/Services/newapps/Fingerprint%20Submission%20Instructions%20-%20Effective%2001.01.2024.pdf</a> .		✓	✓	✓
• Copy of a bond in an amount of \$100,000 made payable only to the State of Nevada. This must be current to maintain a Nevada Wholesaler registration. Complete the <b>Surety Bond form</b> at: <a href="http://bop.nv.gov/Services/newapps/Business/">http://bop.nv.gov/Services/newapps/Business/</a> .		✓	✓	✓

I certify under penalty of perjury that the information contained in this application is accurate, true and complete in all material respects. I understand that making any false representation in this application is a crime under NRS 639.281. I understand that, pursuant to NRS 239.010, this entire application and any portion thereof is a public record unless otherwise declared confidential by law, and will be considered by the Nevada State Board of Pharmacy at a public meeting pursuant to NRS 241.020. In the event this application is approved I agree to comply with all applicable federal and state statutes and regulations governing this license or registration and understand that any violation may result in discipline. I further certify compliance with NRS 639.590 and NAC 639.594 as applicable.

\_\_\_\_\_  
Facility Name

\_\_\_\_\_  
Print Name of Authorized Person Submitting Application

\_\_\_\_\_  
Original signature of Authorized Person (copies or stamps not accepted)

\_\_\_\_\_  
Date

Board Use Only	Date Received: _____	Amount: _____
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# NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, Nevada 89521

(775) 850-1440 • 1-800-364-2081 • FAX (775) 850-1444

• Web Page: [bop.nv.gov](http://bop.nv.gov)

Applicant Name: \_\_\_\_\_

**Payment:** Pay application fee by providing your credit or debit card information below, or by submitting a check made payable to **Nevada State Board of Pharmacy**.

**Credit Cards are charged a 5% processing fee**

**Credit Type:**

☐ Visa   ☐ MasterCard   ☐ Discover

☐ American Express

**Credit Card #:**

\_\_\_\_\_

**Expiration Date:**

\_\_\_ / \_\_\_ (MM/YY)

**CVV (3 digits on back of card):**

\_\_\_\_\_

**License Amount:**

\$ \_\_\_\_\_

**Name on Card:**

\_\_\_\_\_

**Billing Address:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_