MAILING ADDRESS:
MISSOURI BOARD OF PHARMACY
P.O. BOX 625
JEFFERSON CITY, MO 65102
(573) 751-0091

DELIVERY ADDRESS:
3605 MISSOURI BOULEVARD
JEFFERSON CITY, MO 65109

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

OUT OF STATE DRUG MANUFACTURER REGISTRANT APPLICATION

INSTRUCTIONS

1. A copy of the most recent complete FDA inspection or letter with a satisfactory rating dated within the previous two (2) year period must be attached. **Abbreviated reports completed by FDA will not satisfy this requirement.** If your facility has not been inspected by FDA within the last two (2) years, you do not qualify for registration, and must obtain full licensure as a drug distributor.
2. A License Verification Affidavit must be completed by the licensing agency of the state in which you are located verifying current licensure or that licensure is not required in that state and must accompany this application.
3. Registration fee of $10.00.
4. This facility must be used for both the **production (manufacture) and distribution** of legend drugs or devices to be eligible for drug distributor **registration**, in lieu of licensure.
5. If this facility is used for distribution only or distributes for another entity, a **Drug Distributor License Application** must be completed.

FOR OFFICE USE ONLY	
REGISTRATION NUMBER	
DATE REQUESTED	DATE MAILED

1. APPLICANT NAME (SOLE PROPRIETOR, CORPORATION, PARTNERSHIP, LLC, LLP)

2. APPLICANT ADDRESS (STREET, CITY, STATE, ZIP CODE)

3. D/B/A NAME - INDICATE NAME OF DISTRIBUTION FACILITY

D/B/A/ TELEPHONE NUMBER ( )

4. D/B/A/ MAILING ADDRESS (STREET, CITY, STATE, ZIP CODE, COUNTY)

D/B/A/ PHYSICAL ADDRESS (STREET, CITY, STATE, ZIP CODE, COUNTY)

5. THE APPLICANT IS (CHECK ONE)
☐ SOLE PROPRIETOR ☐ PARTNERSHIP ☐ CORPORATION ☐ LLC ☐ LLP

IF A CORPORATION OR LLC, INDICATE STATE OF INCORPORATION

NOTE: If sole proprietor, complete question #6

6. Pursuant to Section 324.010 RSMo:

☐ **CHECK THIS BOX ONLY IF IN ALL OF THE LAST 3 YEARS: YOU WERE NOT A MISSOURI RESIDENT, YOU DID NOT HAVE ANY MISSOURI INCOME, AND YOU ARE NOT SUBJECT TO ANY TYPE OF MISSOURI INCOME TAX.**

False statements are subject to criminal penalties and/or license discipline.

If you have any questions regarding taxes contact the Department of Revenue at 573-751-7200 or e-mail income@dor.mo.gov.

7. TYPE OF PRODUCTS DISTRIBUTED

☐ HUMAN PRESCRIPTION DRUGS ☐ VETERINARY PRESCRIPTION DRUGS ☐ CONTROLLED SUBSTANCES ☐ LEGEND MEDICAL GAS ☐ LEGEND DRUG-RELATED MEDICAL DEVICES

IF YOU CHECK THE CONTROLLED SUBSTANCE BOX, YOU MUST ATTACH COPIES OF YOUR STATE & FEDERAL CONTROLLED SUBSTANCE LICENSES.

I, the above named applicant, do solemnly swear or affirm that the information contained in the foregoing application is true and correct and that this out-of-state manufacturing facility is used for both the production (manufacture) and distribution of legend drugs/devices.

MUST BE SIGNED IN PRESENCE OF NOTARY	APPLICANT SIGNATURE ▶		PRINT NAME
NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE		COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF	YEAR	**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		

Eric R. Greitens
Governor
State of Missouri

Kathleen (Katie) Steele Danner, Division Director
DIVISION OF PROFESSIONAL REGISTRATION

Department of Insurance
Financial Institutions
and Professional Registration
Chlora Lindley-Myers, Director

MISSOURI BOARD OF PHARMACY
3605 Missouri Boulevard
P.O. Box 625
Jefferson City, MO 65102-0625
573-751-0091 PHONE
573-526-3464 FAX
800-735-2966 TTY Relay Missouri
800-735-2466 Voice Relay Missouri

Kimberly A. Grinston
Executive Director
www.pr.mo.gov/pharmacists
email: MissouriBOP@pr.mo.gov

IT MAY BE NECESSARY FOR BOARD OFFICE STAFF TO CONTACT SOMEONE WITH QUESTIONS ABOUT THE ENCLOSED APPLICATION. PLEASE PROVIDE CONTACT INFORMATION BELOW AND SUBMIT WITH THE APPLICATION.

PHARMACY/DRUG DISTRIBUTOR NAME (as on application)	
NAME OF PERSON TO CONTACT	
TITLE OF PERSON TO CONTACT	
ADDRESS OF PERSON TO CONTACT	STREET: CITY, STATE, ZIP:
DIRECT TELEPHONE NUMBER OF PERSON TO CONTACT (include extension)	
FAX NUMBER OF PERSON TO CONTACT	
EMAIL ADDRESS OF PERSON TO CONTACT	

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STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

DRUG DISTRIBUTOR LICENSE VERIFICATION AFFIDAVIT

APPLICANT

1. Complete items 1-6 only on this form.
2. Forward the form to the licensing agency for the state in which you are located. Check with that agency for verification of fee charges.
3. DO NOT RETURN this form to the Missouri Board of Pharmacy unless it has been completed by the state in which you are located.

ORIGINAL IS REQUIRED WITH BOARD SEAL - COPIES WILL NOT BE ACCEPTED

1. DRUG DISTRIBUTOR DBA NAME

2. ADDRESS (STREET, CITY, STATE, ZIP CODE)

3. APPLICANT NAME (CORPORATION, PARTNERSHIP, SOLE PROPRIETOR, LLC, LLP)

4. I HEREBY AUTHORIZE THE _____ *(STATE TO WHICH SENDING FORM)* TO FURNISH TO THE MISSOURI BOARD OF PHARMACY THE INFORMATION REQUESTED BELOW.

5. SIGNATURE OF SOLE PROPRIETOR, PARTNER, OR CORPORATE OFFICER OF APPLICANT

6. PRINT NAME

DO NOT WRITE BELOW THIS LINE - FOR LICENSING AGENCY ONLY

DRUG DISTRIBUTOR LICENSURE IS REQUIRED IN THIS STATE

☐ YES ☐ NO

LICENSE NUMBER	LICENSE STATUS	DATE LICENSE ISSUED	DATE LICENSE EXPIRES

HAS THIS LICENSE BEEN DISCIPLINED IN ANY WAY?	TYPE OF DISCIPLINE
☐ YES ☐ NO	☐ REVOKED ☐ SUSPENDED ☐ PROBATION ☐ CENSURE ☐ LIMITED ☐ RESTRICTED ☐ SURRENDERED

ATTACH CERTIFIED COPIES OF ALL PERTINENT LEGAL DOCUMENTS

ATTACH COPY OF MOST RECENT INSPECTION REPORT CONDUCTED BY HOME STATE BOARD OF PHARMACY

BOARD SEAL AREA *(AFFIX OFFICIAL STATE SEAL OF LICENSING AGENCY BELOW)*

RETURN COMPLETED FORM TO:

MISSOURI BOARD OF PHARMACY
P.O. BOX 625
JEFFERSON CITY, MO 65102

SIGNATURE	TITLE	STATE	DATE