Hospital Pharmacy Associated Clinics Application Packet

Contents:

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Pharmacy Quality Assurance
Commission Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

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Pharmacy Commission
P.O. Box 47877
Olympia WA 98507-7877
360-236-4700

Hospital Pharmacy Associated Clinics Instructions Checklist

When your addendum for a hospital pharmacy associated clinic is received by the Department of Health, you will be notified of any outstanding documentation needed to complete the process.

Indicate type of application

- **New Clinic**—The clinic(s) you are adding to your hospital pharmacy license have not been previously associated with your license.
- **Update to Current Clinic**—You are making an update or change to a clinic(s) that you currently have listed as associated with your hospital pharmacy.

Note: If you are removing a clinic(s) from your hospital pharmacy, this form is not required. Please refer to **WAC 246-945** to remove an associated clinic.

☐ **Application Fees:** Fees are non-refundable. You can check the online **fee page** for current fees.

☐ **1. Demographic Information:**

Uniform Business Identifier Number (UBI #): Enter your Washington State UBI #. All Washington State businesses must have UBI #'s. City, county, and state government departments also have UBI#'s.

Federal ID Number (FEIN #): Enter your Federal ID Number, if the business has been issued one.

Legal Owner/Operator Name: Enter the owner's name as it appears on the UBI/Master Business License.

Email and Web Address: Enter the owner's email and agency Web addresses, if they have them.

Pharmacy License #: Enter the license number of the parent hospital pharmacy.

Pharmacy Name: Enter the pharmacy's name as advertised on signs, brochures or Web sites.

Physical Address: Enter the agency's physical street location including city, state, zip code, and county.

Phone and Fax Numbers: Enter the agency's phone and fax number.

☐ **2. Hospital Pharmacy Associated Clinics (HPAC) Locations:**
Complete this section for each clinic location you are adding under the hospital pharmacy license.

☐ **3. Signature:**
Signature of legal owner or authorized representative.
Date signed.
Print name of legal owner or authorized representative.
Print title of legal owner or authorized representative.
Signature of pharmacist in charge.
Date signed.
Print name of pharmacist in charge.
Print title of pharmacist in charge.

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Washington State Department of HEALTH

Date Stamp Here

Revenue: 0262010000

Hospital Pharmacy Associated Clinics Form

Complete this form if you are adding a new clinic or updating existing clinic information under your pharmacy hospital license. This form must be complete by the Hospital Pharmacy.

Select One: ☐ New Clinic ☐ Update to current clinic

1. Demographic Information

UBI #	Federal Tax ID (FEIN) #
Legal Owner/Operator Name	
Pharmacy License #	
Hospital Pharmacy Name	
Physical Address	

City	State	Zip Code	County

Facility Phone (enter 10 digit #)	Fax (enter 10 digit #)

2. Hospital Pharmacy Associated Clinics (HPAC) Locations

Clinic Name	Clinic Phone #
Site Address	

City	State	Zip Code	County

Does this clinic possess controlled substance? ☐ Yes ☐ No If yes, please list your DEA #.	DEA #

Check which service your HPAC provides:

☐ **Category 1**—The HPAC receives drugs transferred from the parent hospital pharmacy and does not perform sterile or non-sterile compounding of drugs.

☐ **Category 2**—The HPAC received drugs transferred from the parent hospital pharmacy and performs sterile or non-sterile compounding of drugs.

Clinic Name				Clinic Phone #
Site Address				
City	State	Zip Code	County	
Does this clinic possess controlled substance? ☐ Yes ☐ No If yes, please list your DEA #.		DEA #		

Check which service your HPAC provides:

☐ **Category 1**—The HPAC receives drugs transferred from the parent hospital pharmacy and does not perform sterile or non-sterile compounding of drugs.

☐ **Category 2**—The HPAC received drugs transferred from the parent hospital pharmacy and performs sterile or non-sterile compounding of drugs.

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Site Address				
City	State	Zip Code	County	
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Clinic Name				Clinic Phone #
Site Address				
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Does this clinic possess controlled substance? ☐ Yes ☐ No If yes, please list your DEA #.		DEA #		

Check which service your HPAC provides:

☐ **Category 1**—The HPAC receives drugs transferred from the parent hospital pharmacy and does not perform sterile or non-sterile compounding of drugs.

☐ **Category 2**—The HPAC received drugs transferred from the parent hospital pharmacy and performs sterile or non-sterile compounding of drugs.

3. Signature

I certify I have received, read, understood, and agree to comply with state law and rule regulating this licensing category. I also certify the information herein submitted is true to the best of my knowledge and belief.

Signature of Owner/Authorized Representative of Pharmacy

Date

Print Name

Print Title

Signature of Pharmacist in Charge

Date

Print Name of Pharmacist in Charge

Print Title of Pharmacist in Charge