Commonwealth of the Northern Mariana Islands
HEALTH CARE PROFESSIONS LICENSING BOARD
P.O. Box 502078, Bldg., 1242 Pohnpei Court
Capitol Hill, Saipan, MP 96950
Tel No: (670) 664-4809 Fax: (670) 664-4814
Email: cnmi@cnmibpl-hcplb.net
Website: cnmibpl-hcplb.net

PHARMACY APPLICATION

APPLICANT, PLEASE NOTE: EVERY PERMIT UNDER THIS AUTHORITY SHALL BE DEEMED TO BE PERSONAL AND MAY NOT IN ANY CIRCUMSTANCES BE TRANSFERRED TO ANY OTHER PERSON. A SEPARATE APPLICATION MUST BE FILED FOR EACH PERMIT. THERE MUST BE A PERMIT FOR EACH SEPARATE BUSINESS LOCATION.

1. FULL NAME OF APPLICANT _____
Last First Middle

DOING BUSINESS AS (Business name as advertised) _____
Complete Name of Business

2. BUSINESS MAILING ADDRESS _____
P.O. Box or Street No.

BUSINESS LOCATION (Physical Address) _____
Street No. or Village

3. TYPE OF FIRM (check and complete one)

Business Phone No. _____

Hours of Operation _____

_____ A. CORPORATION

1. Is Business a foreign Corporation _____ yes _____ no
2. Is it registered under the law of the CNMI _____ yes _____ no
3. Is it registered under the law of the United States _____ yes _____ no

If "yes", which state _____ Date of Incorporation _____

_____ B. PARTNERSHIP (List name and address of each partner)

1. _____ _____
Last First Middle Address
2. _____ _____
Last First Middle Address
3. _____ _____
Last First Middle Address

_____ C. SOLE PROPRIETOR

_____ D. OTHER (SPECIFY) _____

4. AGENT FOR SERVICE – Agent authorized to accept services of process in legal proceeding against the Corporation

1. Name of Agent: _____
2. Title of Agent: _____
3. Local Address of Agent: _____

5. Federal Tax ID Number _____ **CNMI Tax ID Number** _____

6. Authorized Representative _____

Mailing Address _____

Phone Number _____ **Fax Number** _____ **e-Mail** _____

7. DEA NO. _____ **Expires** _____

8. APPLICATION TYPE

New_____ Renewal _____ Change of Location _____ Change of Ownership _____

9. TYPE OF PHARMACY LICENSE

Wholesale _____ Hospital _____ Community/Retail _____ Mail-Order _____

10. SUB-TYPE – if applicable

Nuclear _____ Remote Dispensing Site _____ Tele-Pharmacy _____ Specialty _____

11. COORDINATING PHARMACY – (Remote Dispensing Site or Tele-Pharmacy Only)

Name _____ CNMI License No. _____ Expires_____

Address _____ City _____ State _____ Zip Code_____

On-Site Certified Pharmacy Technician _____ CNMI License No._____Expires_____

Contact Number _____ E-Mail _____

Visual Check System or Software **(Tele-Pharmacy Only)** _____

12. STATE OF LICENSURE for FACILITY (Non-Residents Only) _____ License No._____ Expires_____

13. PHARMACIST IN CHARGE

Name _____State of Licensure_____ License Number _____ Expires_____

Contact Number _____ E-mail _____

14. OWNERSHIP – List names and titles of all owners, Corporate Officers, Managers, Partners or Members

Attach additional sheets if necessary

Name	Address	Phone Number	Title
1.			
2.			
3.			
4.			
5.			

15. BACKGROUND

1. Have any applicants, partners, or managers had a suspension, revocation, or restriction of a professional license?

YES_____ NO_____ If "Yes" , please list and explain on a separate sheet of paper

2. Have any applicants, partners, or managers been found guilty of a drug or controlled substance violation?

YES_____ NO_____ If "Yes" , please list and explain on a separate sheet of paper

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____ _____

Name and Signature of Authorized Person | Title | Date