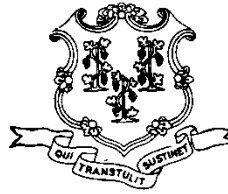


**STATE OF CONNECTICUT**  
**DEPARTMENT OF CONSUMER PROTECTION**  
 DRUG CONTROL DIVISION  
 Telephone: (860) 713-6065  
 Website: [www.ct.gov/dcp/dcd/](http://www.ct.gov/dcp/dcd/)  
 Email: DCP.DrugWholesalers@ct.gov



For Official Use Only

**Application for Wholesaler of Drugs, Medical Devices and/or Cosmetics  
 Outside the State of Connecticut**

**Please Return completed applications and fee to:**

Department of Consumer Protection  
 License Services Division  
 165 Capitol Avenue  
 Hartford, CT 06106

**Fees**

- Wholesaler with **NO** controlled substances = \$190
- Wholesaler with controlled substances = \$375

**Make check or money order payable to  
 "Treasurer, State of Connecticut"**

**This registration expires on June 30<sup>th</sup> every year**

Name of Company, Firm, or Corporation under which function is performed

- Sole Proprietor     Corporation     Limited Liability Company     Partnership     Other (explain)

**Facility Location**

Street Address		City	State	Zip Code
Email Address		Website		
Telephone Number (With Area Code)	FEIN Number	Name of the Facility Manager		

**Mailing Address (If different from the Facility Address)**

Street Address	City	State	Zip Code
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**Types of Products Distributed into the State of Connecticut**

<p>Please select only those products/functions that you intend to wholesale/engage in at the time of completing this document:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> RX Legend Drugs</li> <li><input type="checkbox"/> Non-Rx Legend Drugs (patent medicines, proprietary, over-the-counter, etc.)</li> <li><input type="checkbox"/> Cosmetics</li> <li><input type="checkbox"/> Medical Devices (Legend or Non-Legend)</li> <li><input type="checkbox"/> Reverse Distributor</li> <li><input type="checkbox"/> Medical Gases (including oxygen)</li> <li><input type="checkbox"/> Durable Medical Equipment</li> </ul>	<p><b>Controlled Substances</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Schedule II</li> <li><input type="checkbox"/> Schedule III</li> <li><input type="checkbox"/> Schedule IV</li> <li><input type="checkbox"/> Schedule V</li> <li><input type="checkbox"/> Reverse Distribution of Controlled Substances</li> </ul> <p><i>If selecting any controlled substance you will need to provide a copy of your DEA registration</i></p>
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Has the corporation or any of the officers thereof, or any partner or the individual owner been convicted of a violation of any law of the United State or any state relating to controlled drugs?     Yes     No    **If yes please give details on an attached explanation**

Has this wholesaler every received written advisements, disciplinary action or warnings by ANY regulatory agency (State or Federal) or is any action pending?     Yes     No    **If the answer to this question is yes you must submit a copy with this application**

## Primary Customer Type

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Pharmacies    | <input type="checkbox"/> Variety Stores    | <input type="checkbox"/> Consumer (Medical Oxygen) |
| <input type="checkbox"/> Hospitals     | <input type="checkbox"/> Department Stores | <input type="checkbox"/> Grocery Stores            |
| <input type="checkbox"/> Practitioners | <input type="checkbox"/> Commercial Firms  | <input type="checkbox"/> Other _____               |

Please include the following information as an attachment to this application:

**Failure to supply the information requested will result in a delay**

1. A copy of the license that you have from the state in which your facility resides (or documentation that your state does not require licensure/registration)
2. A copy of your Drug Enforcement Administration (DEA) registration if you have selected any of the controlled substances
3. Any accreditation that your company maintains (Verified-Accredited Wholesale Distributer (VAWD), Joint Commission, etc.)
4. Please provide a list of the following (circle N/A if it does not apply to your company):
  - a. All trade or business names used by the registrant - N/A
  - b. Addresses, telephone numbers, and the names of contact persons for all facilities used by the registrant for the storage, handling, and distribution of prescription drugs
  - c. The name(s) of the owner and/or operator of the registrant including:
    - i. If a person, the name of the person
    - ii. In a partnership, the name of each partner, and the name of the partnership
    - iii. If a corporation, the name and title of each corporate officer and director, the corporate name, and the name of the State of incorporation
    - iv. If a sole proprietorship, the full name of the sole proprietor and the name of the business entity

Name of Person Completing Form

Phone Number of Person Completing Form

Email Address of Person Completing Form

- ❖ Prior to doing business as a Wholesaler of Drugs, Medical Devices and/or Cosmetics you must verify that you have an active registration with the Drug Control Division or have received a certificate.

I certify that the information contained in this application is the truth to the best of my knowledge and have attached all of the documents required that are applicable to this registration.

Signature of Applicant: \_\_\_\_\_

Printed Name and Title: \_\_\_\_\_ Date: \_\_\_\_\_