CSW/OOS/6-13

STATE OF CONNECTICUT
DEPARTMENT OF CONSUMER PROTECTION
DRUG CONTROL DIVISION
Telephone: (860) 713-6065
Website: 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 30th 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

Types of Products Distributed into the State of Connecticut

Please select only those products/functions that you intend to wholesale/engage in at the time of completing this document:
- ☐ RX Legend Drugs
- ☐ Non-Rx Legend Drugs (patent medicines, proprietary, over-the-counter, etc.)
- ☐ Cosmetics
- ☐ Medical Devices (Legend or Non-Legend)
- ☐ Reverse Distributor
- ☐ Medical Gases (including oxygen)
- ☐ Durable Medical Equipment

Controlled Substances
- ☐ Schedule II
- ☐ Schedule III
- ☐ Schedule IV
- ☐ Schedule V
- ☐ Reverse Distribution of Controlled Substances

If selecting any controlled substance you will need to provide a copy of your DEA registration

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

☐ Pharmacies	☐ Variety Stores	☐ Consumer (Medical Oxygen)
☐ Hospitals	☐ Department Stores	☐ Grocery Stores
☐ Practitioners	☐ Commercial Firms	☐ 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:_____