INSTRUCTIONS

APPLICATION FOR WHOLESALE DRUG DISTRIBUTOR'S LICENSE OR THIRD PARTY LOGISTICS (3PL) PROVIDER LICENSE

Purpose

The Federal Prescription Drug Marketing Act of 1987 requires that all entities engaged in the interstate wholesale distribution of prescription drugs for human use be licensed in each state where they are engaged in such activity.

FAILURE TO COMPLETE THE ENTIRE APPLICATION

WILL RESULT IN DELAYS FOR YOUR APPLICATION.

Fill in every box on the application. Use N/A sparingly for Not Applicable or Not Available. Read the remainder of the instructions *carefully* before completing the application. The Illinois Wholesale Drug Distributor Act and the Rules for the Administration of the Act with all Wholesale Drug Distributor requirements are available online at: **http://www.idfpr.com/profs/WholesaleDrug.asp**

☐ The Designated Representative must complete the Designated Representative Attestation (DRA-WDD)

☐ On a separate sheet of paper supply names, home addresses, and birth date of all partners, members, officers, directors, or shareholders owning 5% or more of the outstanding shares.

☐ On a separate sheet of paper list the name and address of any other facility owned by the business submitting the application. If the facility is licensed to do business in Illinois, include the **Illinois** license number.

☐ Corporations or LLCs must submit a copy of their filed Articles of Incorporation/Organization.

☐ Partnerships, Corporations or LLCs **Doing-Business-As (DBA)** or operating under an **Assumed Name** must submit documentation of registering the name with:

Sole Proprietor/ Partnership:	County Clerk's Office where the assumed name is filed.
Corporation/ LLCs:	Illinois Secretary of State (or other jurisdiction's business authority).

☐ Foreign Corporations (Businesses incorporated/organized outside of Illinois) with a facility located inside Illinois must submit a Certificate of Authority from the Illinois Secretary of State.

Facilities **located outside of Illinois** must submit:

- ☐ Certification of Licensure (form CT-PH) completed by the Wholesale Drug Distributor licensure authority in the state where the facility is located (The name and address should match the name and address on your application); **AND**
- ☐ A photocopy of the current Wholesale Drug Distributor license and Controlled Substance license for the state where the facility is located (The name and address should match the name and address on your application); **AND**
- ☐ A photocopy of your current DEA registration (The name, address, and drug schedules should match the name, address, and drug schedules on your application); **AND**
- ☐ A photocopy of your most recent inspection report (The name and address should match the name and address on your application).

INSTRUCTIONS - Continued

Distributors of Controlled Substances

If you plan to distribute controlled substances in Illinois, you must obtain an Illinois Controlled Substance License. If you are already licensed, submit a copy of the license. If you are not licensed, or have not previously applied for this license, an application has been enclosed for your convenience.

Fees

Initial license or Change of Ownership	$200
Change of Designated Representative	$ 50
Change of Location	$100
Facility / Business name change	$100

Fees are Nonrefundable

Checks should be made payable to IDFPR

Distributors Located In Illinois

A separate license is required for each facility directly (or indirectly) owned or operated by the same business that distributes prescription drugs.

Mailing Address

Mail the completed application with the fee in the form of a check or money order to:

Department of Financial and Professional Regulation
Attn: Division of Professional Regulation
P.O. Box 7007
Springfield, Illinois 62791-7007

Telephone No.

For assistance in completing your application call: **1-800-560-6420**

License No.:_____

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 120 (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

TYPE OF LICENSE:

- ☐ **004 WHOLESALE DRUG DISTRIBUTOR**
- ☐ **278 THIRD PARTY LOGISTICS PROVIDER (3PL)**

If you plan to distribute controlled substances in Illinois, you must also obtain an Illinois Controlled Substance License. If you have a current controlled substance license, submit a copy of the license.

TO BE COMPLETED BY ALL APPLICANTS

1. TYPE OF APPLICATION
   - ☐ New License
   - ☐ Change of Ownership
   - ☐ Change of Location
   - ☐ Change of Name of Licensed Facility
   - ☐ Change of Designated Representative
2. NAME OF PARTNERSHIP, CORPORATION OR LLC
3. DOING BUSINESS AS (DBA) / ASSUMED NAME
4. FEIN NUMBER
5a. DESIGNATED REPRESENTATIVE
5b. SOCIAL SECURITY NUMBER
5c. DATE OF BIRTH
6. PRINCIPAL ADDRESS OF FACILITY (Include Street, City, State and ZIP Code)
7. COUNTY
8. PHONE NO. (Include Area Code)
9. EMAIL ADDRESS
10. TYPE OF OWNERSHIP
    - ☐ Individual
    - ☐ Partnership
    - ☐ Corporation
    - ☐ Limited Liability Company
11. NUMBER OF SUBSIDIARIES, RELATED ORGANIZATIONS, ENTITIES OR OTHER FACILITIES OPERATING UNDER OWNERSHIP OF ABOVE. (Attach a separate sheet if needed.)
12. DISTRIBUTOR CATEGORY
    - ☐ Wholesale Drug Distributor
    - ☐ Buying Group
    - ☐ Manufacturer
    - ☐ Repackager
    - ☐ Distribution Center for Multiunit (Chain)
    - ☐ Pharmacy Distributor
    - ☐ Import/Export
    - ☐ Broker
    - ☐ 3PL
13. SALES OF DRUGS TO: (CHECK ALL THAT APPLY)
    - ☐ Community Pharmacies
    - ☐ Hospital Pharmacies
    - ☐ Nursing Home Pharmacies
    - ☐ Distributors/Jobbers
    - ☐ Individual Practitioners
    - ☐ Wholesalers
    - ☐ Repackagers
    - ☐ Other (describe): _____
14. TYPES OF DRUGS DISTRIBUTED (CHECK ALL THAT APPLY)
    - ☐ Noncontrolled Prescription Drugs
    - ☐ Controlled Substances
    - ☐ Nonprescription (OTC)
    - ☐ Other (specify): _____

SECTION I

COMPLETE ONLY IF ILLINOIS IN-STATE FACILITY

APPROXIMATE DATE FACILITY WILL BE READY FOR INSPECTION

SECTION II

COMPLETE ONLY IF OUT-OF-STATE APPLICANT

a. State(s) Currently Licensed In

b. License Number(s)

SECTION III

COMPLETE ONLY IF CHANGE OF OWNERSHIP

a. Principal Address of Facility

b. Previous Illinois Drug Distributor License Number

c. Date of Acquisition

SECTION IV

COMPLETE ONLY IF CHANGE OF LOCATION

a. Previous Address of Facility

b. Illinois Drug Distributor License Number

c. Date of Proposed Opening

SECTION V

COMPLETE ONLY IF CHANGE OF DESIGNATED REPRESENTATIVE

a. Previous Designated Representative

Current, original Illinois license must be returned with this application.

b. Current Illinois Drug Distributor License Number

c. Effective Date of Change

SECTION VI

COMPLETE ONLY IF CHANGE OF FACILITY / BUSINESS NAME

a. Previous Legal Name

b. Is this a change of ownership? ☐ Yes ☐ No

c. Current Illinois Drug Distributor License Number

d. Effective Date of Change

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com

TO BE COMPLETED BY ALL APPLICANTS

14.a. Has applicant, or any names therein listed, ever been charged in a court of law, hearing, or other administrative procedure with any violation of the laws of the United States or of any individual state, relating to drugs, liquor, poisonous substance or any felony offense? ☐ Yes ☐ No

(If "Yes," state all particulars, dates, places, and present status on separate sheet.) Submit certified court documents relating to the offense.

b. Has applicant, or any persons listed above, ever had any disciplinary action taken against him or been convicted of any violation of the laws of the United States or of any individual state, relating to the manufacure, distribution, or dispensing of Controlled Substances? ☐ Yes ☐ No

(If "Yes," state all particulars, dates, places, and present status on separate sheet.) Submit copy of disciplinary records from individual state(s).

I do solemnly swear or affirm that the answers appearing hereon are true and correct to the best of my knowledge and belief, and that I am legally authorized to sign for this business. Additionally, I meet the requirements of six (6) years education and/or experience to qualify for this position.

Date	Designated Representative
Date	Owner, Partner or Corporate Officer

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

Legal Name of Business:

FEIN or SS#:

Profession Name: WHOLESALE DRUG DISTRIBUTOR

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 120 et.seg. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

DESIGNATED REPRESENTATIVE ATTESTATION

SUPPORTING DOCUMENT

DRA-WDD

PART I: Wholesale Drug Distributor OR Third Party Logistics (3PL) Provider Facility Information

A. NAME OF PARTNERSHIP, CORPORATION, OR LLC	B. FEIN NUMBER
C. DOING BUSINESS AS (DBA) / ASSUMED NAME	D. CURRENT ILLINOIS LICENSE NUMBER (If new application or change of ownership, write N/A.)
E. PRINCIPAL ADDRESS OF FACILITY (Include Street Address, City, State, and ZIP Code)	F. TELEPHONE NUMBER (Include Area Code) G. DESIGNATED REPRESENTATIVE
H. TYPE OF OWNERSHIP ☐Corporation ☐Partnership ☐Individual ☐Limited Liability Company	I. EMAIL ADDRESS

PART II: *This portion is to be completed by the Designated Representative.*

A. NAME (Last, First, Middle Initial)	B. TITLE OR POSITION HELD WITH FACILITY
C. RESIDENCE ADDRESS (Include Street, City, State, and ZIP Code	D. SOCIAL SECURITY NUMBER E. DATE OF BIRTH

F. PERSONAL HISTORY QUESTIONS		YES	NO
1.	Have you ever been charged in a court of law, hearing, or other administrative procedure with any violation of the laws of the United States or of any individual State, relating to drugs, liquor, poisonous substance or any felony offense? (If "Yes" state all particulars, dates, places and present status on separate sheet. Also, submit certified court documents relating to the offense.)		
2.	Have you ever had any disciplinary action taken against you or been convicted of any violation of the laws of the United States or any individual State relating to the manufacture, distribution, or dispensing of controlled substances? (If "Yes" state all particulars, dates, places and present status on separate sheet. Also, submit certified court documents relating to the offense.)		
3.	Are you physically present at the facility during regular business hours?		
4.	Are you serving in the capacity of a designated representative for only one facility at a time?		

THE FOLLOWING QUESTIONS DO **NOT** APPLY TO 3PL LICENSE APPLICANTS (NOS. 5-8)

5.	(WDD ONLY) Are you employed by the Wholesale Drug Distributor facility full time in a managerial level position?		
6.	(WDD ONLY) Are you actively involved in and aware of the actual daily operations of the facility?		
7.	(WDD ONLY) Have you been employed full-time for at least 3 years in a pharmacy or with a wholesale distributor in a capacity related to the dispensing and distribution of, and recordkeeping relating to prescriptions?		

8. (WDD ONLY) LIST ALL FULL-TIME EMPLOYMENT IN THE LAST 3 YEARS IN A PHAMACY OR WHOLESALE DRUG DISTRIBUTOR

NAME OF BUSINESS AND ADDRESS (Include Street, City, State, Zip Code)	POSITION	DATES OF EMPLOYMENT	DUTIES

Name of Wholesale Drug Distributor:

FEIN :

Profession Name:

PART III: Certifying Statement

Under penalties of perjury, I declare that I have examined this supplemental application, that the answers appearing hereon are true and correct to the best of my knowledge and belief, and that I am the person listed in Part II, A, above.

Date

Signature of Person Responsible For Drugs

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 120 (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

PHARMACY

CERTIFICATION BY LICENSING AGENCY / BOARD

SUPPORTING DOCUMENT

CT-PH

APPLICANT: Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. You are authorized to photocopy this form as necessary.

1. NAME OF BUSINESS, CORPORATION, OR LLC			
2. DBA (ASSUMED NAME)			3. FEIN
4. FACILITY STREET ADDRESS		5. EMAIL ADDRESS (REQUIRED)	
6. FACILITY CITY	7. STATE	8. ZIP CODE	9. TELEPHONE NUMBER (include Area Code)

I hereby authorize _____ to furnish to the Illinois Department of
Other State Licensing Agency
Financial and Professional Regulation the information requested below.

Date _____ Signature of Applicant _____

DO NOT RETURN COMPLETED FORM TO APPLICANT

OTHER STATE LICENSING AGENCY: **The Illinois Department of Financial and Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the Certification. Please record N/A in areas which are not applicable.**

A. LICENSE NUMBER		F. TYPE OF LICENSE
B. LICENSE STATUS		☐ Pharmacy ☐ Wholesale Drug Distributor/Manufacturer ☐ Third Party Logistics (3PL) Provider ☐ Home Medical Equipment / Durable Medical Equipment ☐ Other _____
C. DATE ISSUED	D. DATE LICENSE EXPIRES	
E. HAS THIS LICENSE BEEN ENCUMBERED IN ANY WAY? _____ Yes _____ No **If "yes," please attach certified copies of all pertinent legal documents.**		G. TYPE OF ENCUMBERANCE ☐ Revoked ☐ Suspended / Restricted ☐ Surrendered ☐ Probation ☐ Limited

USE REVERSE SIDE OF THIS FORM FOR EXPLANATIONS.

1. Has the applicant been convicted under any federal, state, or local laws relating to drug samples, wholesale or retail drug distribution, or distribution of controlled substances, or the provision of home medical equipment and its services? ☐ Yes ☐ No
2. Has the applicant furnished any false or fraudulent material in any application made in connection with a pharmacy operation, drug manufacturing or distribution, or home medical equipment or its services? ☐ Yes ☐ No
3. Have any inspections resulted in deficiency ratings? (If yes, please explain.) ☐ Yes ☐ No
4. Has the applicant met all licensing requirements in your state? ☐ Yes ☐ No

BOARD SEAL AREA (affix official State Seal of licensing agency below)	**RETURN FORM TO:**
S E A L	Illinois Department of Financial and Professional Regulation Health Services Section 320 W. Washington Springfield, Illinois 62786
Signature	**Title**
State	**Date**

INSTRUCTIONS FOR
ILLIINOIS WHOLESALE DRUG DISTRIBUTOR
OR
THIRD PARTY LOGISTICS (3PL) PROVIDER
CONTROLLED SUBSTANCES LICENSE APPLICATION

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.

1. Federal registration is mandatory before any activity relating to or the use of controlled substances is permitted.

2. A check or money order made payable to the Illinois Department of Financial and Professional Regulation, must accompany this application. The required fees are:

New License (any / all schedules):	**$50**
New License (Schedule V Only):	**$15**
Change of Ownership:	**$50**
Change of Facility / Business Name	**$20**
Change of Location:	**$20**
Add / Change of Drug Schedules:	**$50**
Add / Change Type of Activity:	**$50**

Mail the completed application and fee to:

Illinois Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
PO Box 7007
Springfield, Illinois 62791

3. (004) Wholesale Drug Distributor License is **required** for (304) Distributor/Manufacturer Controlled Substances License. (278) Third Party Logistics (3PL) Provider License is required for (378) Third PartyLogistics (3PL) Provider Controlled Substances License.

4. Applications for Controlled Substance License for facilities located ***outside of Illinois*** must include a photocopy of a current Drug Enforcement Administration (DEA) Registration.

5. The NAME on the application must correspond with the DEA registration.

6. The license will be issued to the FACILITY address. This must be the address where the activity will be conducted.

7. Upon acceptance and review, complete applications will be forwarded to the Division's Drug Compliance Unit for inspection/final approval.

IMPORTANT: In the State of Illinois, Cannabis and substances derived from it are regulated by the Illinois Cannabis Control Act [720 ILCS 550/1, *et seq*.]. **This application is for substances regulated by the Illinois Controlled Substances Act only.**

ILLINOIS WHOLESALE DRUG DISTRIBUTOR OR THIRD PARTY LOGISTICS PROVIDER CONTROLLED SUBSTANCES LICENSE APPLICATION

FOR OFFICIAL USE ONLY

Important Notice: Completion of this form is required by 720 ILCS 570. Disclosure of this information is MANDATORY. Failure to comply could result in a fine up to $30,000.

1. TYPE OF LICENSE: (check only one)

- ☐ 304 Controlled Substances Manufacturer
- ☐ 304 Controlled Substances Distributor
- ☐ 378 Third Party Logistics (3PL) Provider Controlled SubstancesControlled Substances Distributor

2. TYPE OF APPLICATION: (check only one)

- ☐ $50 New (any / all schedules)
- ☐ $15 New (schedule V only)
- ☐ $50 Change of Ownership _____ Current ILLINOIS License No.
- ☐ Reapplication _____ Current ILLINOIS License No.

3. TYPE OF BUSINESS OWNERSHIP: (check only one)

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ Corporation
- ☐ Limited Liability Corporation (LLC)
- ☐ Government Unit

TYPE OF REAPPLICATION: (check all that apply)

- ☐ $20 Change of Facility / Business Name
- ☐ $20 Change of Location
- ☐ $50 Change of Drug Schedules
- ☐ $50 Add / Change type of Activity

4. NAME OF FIRM, CORPORATION, LLC, GOVERNMENT UNIT

5. DBA (ASSUMED NAME)	6. FEIN	7. EMAIL

8. DESIGNATED REPRESENTATIVE

9. FACILITY STREET ADDRESS

10. FACILITY CITY, STATE, ZIP CODE, COUNTY

11. FACILITY TELEPHONE (Include Area Code)

12. Have you (the applicant) applied for or do you have registration under the Federal Controlled Substances Act?
(Out-of-state applicants must submit a copy of current DEA registration.) Applied: ☐ Yes ☐ No Registered: ☐ Yes ☐ No

13. Check all applicable schedules and list each specific drug handled. Any license issued pursuant to this application applies only to the schedules checked. (Distributors need only to check applicable schedule and do not need to list specific drugs.)

✓	SCHEDULE	LIST SPECIFIC DRUGS
	I	
	II	
	III	
	IV	
	V	

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.

14. BRIEFLY DESCRIBE SECURITY PROVISIONS FOR STORAGE OF THE CONTROLLED SUBSTANCES AND NAME PERSON PRINCIPALLY RESPONSIBLE FOR SECURITY. (You must also include person's Date of Birth, Sex, and Social Security Number.)

15. LIST ALL PERSONS WITH AUTHORITY TO ORDER DRUGS OR THOSE WHO WILL HAVE THE POWER OF ATTORNEY. (Also include Date of Birth, Sex, and Social Security Number.)

FIRMS ENGAGED SOLELY IN MANUFACTURE NEED TO COMPLETE QUESTION 16.

16. LIST ALL PREPARATIONS MANUFACTURED WHICH CONTAIN ANY CONTROLLED SUBSTANCE. (Attach additional page(s) if necessary. The firm's catalog will suffice.)

17. Has applicant, or any names therein listed, ever been charged in a court of law, hearing, or other administrative procedure with any violation of the laws of the United States or of any individual state relating to drugs, liquor, poisonous substances or any felony offense? ☐ Yes ☐ No (If "Yes," state all particulars, dates, places and present status on separate sheet.)

18. Has applicant, or any of the persons listed above, ever had any disciplinary action taken against him or been convicted of any violation of the laws of the United States or of any individual state, relating to the manufacture, distribution, or dispensing of Controlled Substances? ☐ Yes ☐ No (If "Yes," state all particulars, dates, places, and present status on separate sheet.)

I hereby certify that I personally completed this application, that the answers appearing hereon are true and correct to the best of my knowledge and belief, and that I am legally authorized to sign for this business.

Print Name of Owner or Person Designated to Sign for Business

Signature of Owner or Person Designated to Sign for Business

Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

Name of Applicant:

FEIN:

Profession Name:

304 WDD / 378 3PL
CONTROLLED SUBSTANCES LICENSE