

Facility Move or Relocation Notification Form MN-FAC-004

For Resident and Non-Resident Wholesalers and Manufacturers

Instructions: This form should be submitted if a facility is physically changing location or suite numbers. A new license will be issued when the notification and supporting documents are approved and processed.

Non-Resident Facilities must submit this form ONLY after your home state regulatory agency has issued a license showing the new address and an inspection has been conducted of the new location **within 30 days** of the change.

Resident Facilities should complete the relocation application a minimum of **60 days** prior to the date that the physical relocation occurs.

Relocation fee is \$500; however, in accordance with Minnesota Statute section 151.065, if the relocation application is made within 60 days before the date of the original license expiration, the applicant must pay the full application fee provided in Minnesota Statute section 151.065, subd. 1. **All fees are non-refundable.** State of Minnesota Tax ID: 4405717, Federal Tax ID: 41-6007162.

Licenses are mailed to the facility's physical address. The application, supporting documentation, and correct payment must be received by the Board before the change can be processed.

Mail the completed form, documents, and payment to Minnesota Board of Pharmacy, 335 Randolph Avenue, Suite 230, St. Paul, MN 55102. Check should be payable to the Minnesota Board of Pharmacy. All payments are non-refundable.

Checklist for all Applicants

All applicants are required to complete and submit the following:

- ✓ **Certificate of Good Standing** from the state where the facility is located, obtained with the last 24 months.
- ✓ **Notification Form.** Complete the entire form and submit with original signatures, fees, and documents. Do not leave blanks, if an item or question is not applicable, indicate N/A.
- ✓ **Ownership Information.** Include Incorporation Paperwork, Partnership Agreement papers and/or Organizational Agreement papers.
- ✓ **Organizational Chart.** An ownership organizational chart that clearly documents the ownership structure. Include percentages owned by all parties.
- ✓ **List of Officers.** The officers must be identified by name, title and percentage owned if applicable.
- ✓ **List of all Shareholders.** Include the shareholder's name, title, address, city, state, and zip code along with their ownership percentage.
- ✓ **If you are self-insured** and reside in the State of Minnesota, attach a copy of the Certificate of Exemption from the Insurance Commissioner.

Non-Resident Drug Wholesalers

Per MN Statutes §151.252 and §151. 47, the Board shall not issue a license unless the facility passes an inspection conducted by an authorized representative of the Board or is accredited by an accreditation program approved by the board (e.g. Verified-Accredited Wholesale Distributor (VAWD)). You are required to attach a copy of your current license or registration from the state in which your facility is located, and a copy of an inspection from your state that has occurred within the 24 months immediately preceding receipt of the notification form by the Board or proof of current accreditation, and any other documents that relate to an inspection or investigation. Reports from inspections prior to 24 months will NOT be accepted. All applicants must submit evidence that any deficiencies noted in any inspection or investigatory report have been corrected, including any documents that you have provided to state agencies in response to inspections or investigations. The Minnesota Board of Pharmacy determines whether or not a facility has passed an inspection conducted by someone other than a representative of the Board.

In addition to the items for all applicants, the following items are also required:

- ✓ **Current Home State License.** A copy of your current license/registration from the state your facility is located showing the new address, or a letter from your home state explaining that your state does not require a license.
- ✓ **Inspection Report within the last 24 months.** Provide a copy of a full inspection report and any corrective actions on deficiencies or observations made during the inspection, with all related documents from your state, the FDA, or Board approved accreditation program certificate. 'Notices of Inspections' and/or Self-Inspections **do not meet** the Board's inspection requirements.

Non-Resident Drug Manufacturers

This includes, but is not limited to virtual manufacturers, contract manufacturers, repackagers, and labelers. In addition to the items listed for all applicants, the following items must also be submitted with your application.

- √ **FDA Registration.** Provide proof of current FDA Drug Establishment Registration. You must have an FDA registration or we will not issue or renew a license. A printout of your current FDA registration showing the expiration date from the FDA clearing house is acceptable.
- √ **Outsourcing facilities** must hold a current FDA registration as an outsourcing facility and provide proof of such.
- √ **Current Home State License.** A copy of your current license/registration from the state in which your facility is located, or a letter from your home state explaining that your state does not require a license.
- √ **Inspection Report within the last 24 months.** Provide a copy of a full inspection report and any corrective actions on deficiencies or observations made during the inspection, with all related documents, from your state or the FDA. 'Notices of Inspections' and/or Self-Inspections do not meet the Board's inspection requirements.

Resident Wholesalers

- √ Resident wholesalers are asked to submit a blueprint showing the access.

Drug Wholesaler or Manufacturer Move or Relocation Notification - MN-FAC-005

Resident and Non-Resident

FEE: \$500; however, if the relocation application is made within 60 days before the date of the original license expiration, the applicant must pay the full application fee provided in Minnesota Statute section 151.065, subd. 1. Fees are not refundable. Each item on this application must be answered fully, truthfully, and accurately by the applicant. Fraud or deception in securing a license is a misdemeanor and cause for revocation or suspension of a license. All items must be completed. **Resident facilities** should complete this form 60 days prior to the date of relocation. **Non-resident facilities** must complete this form only after the home state regulatory agency has issued a license showing the new address and an inspection has occurred, within 30 days of the change. A new license is issued.

Complete the Information Below for the Applicant

Name of Facility as is Appears on the Home State License	Current MN License #	MN Tax ID	Federal Tax ID	Effective Date of Change
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Current Street Address			NEW Address/Location			Square Footage
City	State	Zip	City	State	Zip	Phone

Hours of Operation

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	No change in hours
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Categories

<p>Check each category you will sell drugs to.</p> <p>Home Health Agency Dentist</p> <p>Pharmacy Nursing Home</p> <p>Medical Doctor Veterinarian</p> <p>Wholesaler Other _____</p>	<p>Check all categories of drugs proposed for handling.</p> <p>Human Prescription Human Non-prescription (OTC)</p> <p>Veterinary Prescription Veterinary Non-prescription (OTC)</p> <p>Controlled Substances Medical Gases</p> <p>Human/Vet drug products made by Outsourcing Facility</p>
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Does the applicant have the required facilities to comply with DEA security regulations? YES NO N/A

Individual Completing Application

Ownership Contact Information

Must be authorized to discuss application materials.

Person authorized to speak on behalf of the owner.

Name	Title	Name	Title
Phone	Email	Phone	Email

Facility Contact Information

Contact Name	Phone	Email
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Minnesota Statute 176.182 requires the applicant to provide acceptable proof of compliance with the workers' compensation coverage provisions before the Board of Pharmacy shall issue a license.

If your facility is not located in the state of Minnesota, do not complete this section. If your facility is in Minnesota, please check the appropriate box below.

This facility does not employ anyone and therefore, will not supply workers' compensation coverage documents.

This facility is self-insured and has attached a **Certificate of Exemption.**

This facility has paid, or compensated employees and has attached a **Certificate of Insurance.**

This facility has paid, or compensated employees and is supplying the insurance company information:

Insurance Co. Name	Policy Number	Policy Expiration Date	Address	Phone Number
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Ownership Information

Owner (Legal Name)		LLC		S Corporation		Limited Partnership		Publicly Traded	
		Corporation		Partnership		Proprietorship			
Address		City		State		Zip		Email Address	
								Phone Number	
State of Incorporation				Number of Shares/Stock Issued					

Read each statement carefully, following the instructions below.

- Answer the questions on this page with the correct ownership type, i.e., if the facility is an LLC, answer only the questions below the, "On behalf of the corporation...".
- If the statement is true, review and attest to each statement below by marking YES or NO.
- If you answer YES to any of the questions that require additional explanation, provide a detailed explanation on a separate document.

On Behalf of the Corporation, S Corporation, or Limited Liability Company (LLC):

Yes No

Has the applicant facility previously applied for a license to operate a facility in Minnesota?

Has the applicant facility applied for a license to operate a facility in any other state?

If yes above, was the application denied by the Board of Pharmacy or appropriate licensing agency?

If the application was denied, attach a separate document with an explanation.

If a license was granted, was it later suspended, revoked, or placed on probation?

In connection with any violations, did the licensing agency issue any warning or reprimands?

If yes, attach a separate document indicating nature of violation, an explanation of why it happened, and a copy of the written findings/warning(s)/reprimand(s).

On Behalf of a Partnership or Sole Proprietor, has the Individual(s):

Yes No

Been convicted of a felony in any court?

If yes, provide all related documentation and/or an explanation on a separate sheet.

Habitually indulged in the illegal use of narcotics, stimulants, or depressant drugs; or habitually indulged in intoxicating liquors in the manner which could cause incompetence in the operation of the facility?

If yes, attach a separate document with an explanation.

Been convicted of theft of drugs or the unauthorized use, possession, or sale thereof?

If yes, attach a separate document with an explanation.

Previously applied for a license to operate a facility in Minnesota?

Applied for a license to operate a facility in any other state?

If yes to the above, was the application denied by the Board of Pharmacy or appropriate licensing agency? **If yes, attach a separate document with an explanation.**

If a license was granted, was it later suspended, revoked, or placed on probation?

In connection with any violations, did the licensing agency issue any warning or reprimands?

If yes, attach a separate document indicating nature of violation and an explanation of why it happened.

The data you supply on this form will be used to assess your qualifications for licensure. You are not legally required to provide this data, but we will not be able to grant the license without it. This data will constitute a public record, when the licensure is granted, and, at that time, copies may be issued to anyone.

Acknowledgment

I have read the above statement and I agree to supply the data on this form with full knowledge of the information provided in that statement. In addition, I, the undersigned, do hereby certify that all the information above is true and correct and that the firm will be operated in compliance with all applicable laws and regulations.