MINNESOTA BOARD OF PHARMACY

Protecting the Public Since 1885 | pharmacy.board@state.mn.us

335 Randolph Avenue, Suite 230 | St. Paul, MN 55102

Facility Move or Relocation Notification Form

For Resident and Non-Resident Third Party Logistics providers

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.

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

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.

Relocation fee is $300.00. 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. All fees are non-refundable. State of Minnesota Tax ID: 4405717, Federal Tax ID: 41-6007162.

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:

- ☐ **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 Applicants

Per Minn. Stat. §151. 471 Subd. 2, the Board shall not issue a license unless the facility passes an inspection conducted by an authorized representative of the Board or is inspected and accredited by an accreditation program approved by the Board. 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 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 a facility has passed an inspection conducted by someone other than a representative of the Board. **If the facility is NABP Verified-Accredited Wholesale Distributors (VAWD) accredited, you may provide the certificate in place of an inspection.**

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 along with the current FDA registration.
- ☐ **Inspection Requirement.** Provide a copy of NABP Verified-Accredited Wholesale Distributors (VAWD) Accreditation *or* a full inspection report and any corrective actions on deficiencies and observations made during the inspection, with all related documents from your state, the FDA, or Board approved accreditation program certificate.

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Third Party Logistics Provider Move or Relocation Notification

Resident and Non-Resident

FEE: $300.00. 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. Upon approval, a new license will be issued.

Complete the Information Below for the Applicant

Name of Facility as it Appears on the Home State License	Current MN License #	MN Tax ID	Federal Tax ID	Effective Date of Change

Current Street Address (or "Previous" for Non-Resident Facilities)			**NEW Physical Address**			**Square Footage**
City	State	Zip	**City**	**State**	**Zip**	**Phone**

Alternate mailing address if different from the physical address:

Mailing Address Line One	Mailing Address Line Two	City	State	Zip

Individual Completing Application

Must be authorized to discuss application materials

Name	Title	Employer

Phone	Email	Address

Facility Manager or Designated Representative: Individual responsible for operations and compliance of facility*

Full Legal Name	Phone	Email

***The Facility Manager or Designated Representative Affidavit Form must accompany this application. Please see Appendix A.**

Business Hours

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Check this box if Open 24/7
							☐

Inspection or Verified-Accredited Wholesale Distributors (VAWD) Accreditation

Facility must meet inspection requirements in Minnesota Statute § 151.471 Subd 2.

◯ YES Yes, VAWD Accredited. **Attach a copy of the current VAWD.**

◯ NO No, the applicant does not have a VAWD accreditation. **Attach a copy of all inspections conducted within the past 24 months.**

Controlled Substances

◯ YES ◯ NO Does the applicant handle or store controlled substances?

◯ YES ◯ NO Is the facility registered with the United States Drug Enforcement Agency (DEA)?

◯ YES ◯ NO If yes, does the facility comply with DEA security regulations for the storage of controlled substances?

Applicant Facility Business Operations

◯ YES ◯ NO Does this location also have a wholesaler license that is currently doing business in Minnesota?

If yes, list the name and license number _____

◯ YES ◯ NO Does the applicant intend to transfer this license to a third-party logistics provider license? **Choosing yes will automatically close out your wholesale license when the 3PL license is approved and licensed.**

Select all categories of drugs you propose to handle, directly or indirectly:			
Active Pharmaceutical Ingredient (API) ☐	Controlled Substances ☐	Opiates ☐	Human Prescription ☐
Human Non-Prescription (Over the Counter or "OTC") ☐	Human/Veterinary drug by Outsourcing Facility ☐	Medical Gasses ☐	Veterinary Prescription ☐
Veterinary Non-Prescription (Over the Counter or "OTC") ☐	Other, Describe:		

Select each category applicant sells or transports drugs or medical gasses to:				
Ambulance ☐	Home Health Agency ☐	Patient Specific Prescription ☐	Hospital ☐	Nursing Home ☐
Pharmacy ☐	Practitioner ☐	Veterinarian ☐	Wholesaler ☐	Manufacturer ☐
Other, Describe:				

MINNESOTA RESIDENT Facility Worker's Compensation Insurance

(Complete only if your facility is in Minnesota)

Minnesota Statute § 176.181 Subd. 2 requires the applicant to provide acceptable proof of compliance with 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.

Resident facilities, check the appropriate box:

☐ 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**.

Ownership Information *- In addition to the table below, please complete Appendix B*

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 us, 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.

_____ _____

Signature of Owner, Partner, Managing Officer, or Authorized Individual Date

MINNESOTA
BOARD OF PHARMACY

Third-Party Logistics (3PL) Facility Manager or Designated Representative Affidavit
Form MN-3PL-001

This form is to be completed by the primary designated representative and is completed when a facility is applying for a third party logistics providers license for the first time. This designated representative serves as a manager and is responsible for ensuring the facility follows all state statutes and rules applicable to the operations.

Instructions: Complete each section, if a section does not apply, put N/A in the space available. If the space available is insufficient, use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s), each statement is subject to verification. All applicants are advised that this personal history record is an official document and misrepresentation or failure to reveal information requested may be deemed to be enough cause for the refusal or revocation of a license for the facility named in this application.

Complete the information below for the Facility

(name and address of business for which designated representative is requested)

Facility Name/DBA	Address	City	State	Zip

Email	Minnesota License #	e-Profile #	Phone

Applicant Information

Facility Manager or Designated Representative responsible for operations and compliance of applicant facility

Full Legal Name	Title	Academic Credentials	Date of Birth	Email

Mailing Address	City	State	Zip	Last 4 Digits of Social Security #

The Facility Manager or Designated Representative for the Applicant Facility must personally complete and attest to the following points of fact regarding this facility's operations.

Read each statement carefully, following the instructions below

- If the statement is true, review and attest to each statement below by marking YES.
- If the statement is not true, mark NO **and** provide a detailed explanation on a separate document referencing the statement.

I certify the following:

○ Yes	○ No	I am the Facility Manager or Designated Representative for the Applicant Facility.
○ Yes	○ No	I have never been convicted of, or plead guilty to any felony violation.
○ Yes	○ No	I do not have any convictions under federal, state, or local law relating to distribution of prescription drugs or controlled substances.
○ Yes	○ No	The Applicant Facility has adequate storage conditions to allow for the safe receipt, storage, handling, and transfer of drugs.
○ Yes	○ No	The Applicant Facility has sufficient policies and procedures in place for the inspection of all incoming and outgoing drug shipments.
○ Yes	○ No	There is a functioning security system that includes an after-hours central alarm or comparable entry detection capability.
○ Yes	○ No	There are security policies and procedures that include provisions for restricted access to the premises, comprehensive employee applicant screening, and safeguards against all forms of employee theft.
○ Yes	○ No	The Applicant Facility maintains records of the handling of drugs, which shall be kept for a minimum of two years and be made available to the board upon request.
○ Yes	○ No	I will ensure that all personnel have sufficient education, training, and experience, in any combination, so that they may perform assigned duties in a manner that maintains the quality, safety, and security of drugs.

Read each statement carefully, following the instructions below.

- If the statement is true, review and attest to each statement below by marking YES.
- If the statement is not true, mark NO and provide a detailed explanation on a separate document referencing the statement.

I certify the following:

○ Yes	○ No	I will ensure that all employees of the Applicant Facility will be evaluated and supervised sufficiently to protect and maintain the quality, safety, and security of drugs.
○ Yes	○ No	I will develop and, as necessary, update written policies and procedures that ensure reasonable preparation for, protection against, and handling of any facility security or operation problems, including, but not limited to, those caused by natural disaster or government emergency, inventory inaccuracies or drug shipping and receiving, outdated drug, appropriate handling of returned goods, and drug recalls.
○ Yes	○ No	I am regularly on-site and actively involved in and aware of the Applicant Facility's actual daily operations.
○ Yes	○ No	I am physically present at the Applicant Facility during normal business hours except when absence is authorized, including but not limited to sick leave and vacation leave.
○ Yes	○ No	I do not serve as the Facility Manager or Designated Representative for more than one Applicant Facility or licensee.
○ Yes	○ No	I will operate in compliance with all state and federal laws and regulations applicable to third-party logistics providers.

Acknowledgment

I, the undersigned, do hereby certify that all the information contained in form and the accompanying application and documents is true and correct and that the Applicant Facility will be operated in compliance with all applicable laws and regulations.

FURTHER AFFIANT SAYETH NOT.

_____ _____ _____
Facility Manager or Designated Representative Signature | Print Name | Date

Notary Acknowledgment

State of _____. I certify the following person personally appeared before me on this day, acknowledging that he or she signed the foregoing document _____.
Name of Facility Manager/Designated Representative

Subscribed and sworn to before me on this _____ day of _____, 20____.

_____
Notary Signature

_____
Print Name of Notary

_____
Date Notary Commission Expires

(Seal)

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Shareholder/Member/Partner Form

Instructions: Select the appropriate checkbox below. If your business is a Non-Profit Corporation or is Publicly Traded you do not need to complete the Shareholders/Members/Partners table below. If part of the parent owner(s) is an ESOP, please list the ESOP and the representative's name. If the space available is insufficient, use a separate sheet. Do not misstate or omit any material fact(s), each statement is subject to verification. All applicants are advised that this record is an official document and misrepresentation or failure to reveal information requested may be deemed to be enough cause for the refusal or revocation of a license this form is submitted for.

☐ Privately Owned ☐ Non-Profit Corporation ☐ Publicly Traded

List All Shareholders/Members/Partners – Attach Additional Sheets if Necessary

Legal Name	Address, City, State, Zip Code	Phone Number	% Owned

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 if 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.

Signature of Designated Rep., Facility Mgr., or Authorized Individual

Date

Type or Print Full Name Above

Title