

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: (608) 266-2112

Ship To: 1400 E. Washington Avenue
Madison, WI 53703
E-Mail: dsps@wisconsin.gov
Website: <http://dsps.wi.gov>

PHARMACY EXAMINING BOARD

WHOLESALE DISTRIBUTOR OF PRESCRIPTION DRUG LICENSE

DESIGNATED REPRESENTATIVE FORM

LICENSURE REQUIREMENTS

All of the following apply to each person identified by the applicant as a Designated Representative:

1. The person is at least 21 years old.
2. The person has been employed full time for at least 3-years in a Pharmacy or with a Wholesale Prescription Drug Distributor in a capacity related to the dispensing and distribution of, and record keeping related to, prescription drugs.
3. The person is employed by the applicant full-time in a managerial level position.
4. *The person is physically present at the Wholesale Prescription Drug Distributor's facility during regular business hours and is involved in and aware of the daily operation of the Wholesale Prescription Drug Distributor. This subdivision does not preclude the Designated Representative from taking authorized sick leave and vacation time or from being absent from the facility for other authorized business or personal purposes.
5. *The person is actively involved in and aware of the daily operations of the Wholesale Distributor.
6. The person is a Designated Representative for only one applicant at any given time. This subdivision does not apply if more than one Wholesale Distributor is located at the facility and the Wholesale Distributors located at the facility are members of an affiliated group.
7. The person has not been convicted of violating any federal, state, or local law relating to wholesale or retail prescription drug distribution or distribution of a controlled substance.
8. The person has not been convicted of a felony.

***To meet the requirements of numbers 4 and 5 above, please fully list and describe the person's duties showing that the person is actively involved in and aware of the daily operations of the wholesale distributor.**

Fingerprinting Instructions:

1. **The named Designated Representative for the Wholesale Distributor facility applying for the license must submit digital fingerprints. All Designated Representatives must submit their fingerprints electronically for a background check.**
2. **This subdivision does not apply to a person accredited by the National Association of Boards of Pharmacy's Verified-Accredited Wholesale Distributor (VAWD) program. Schedule an appointment with the Department's approved vendor, Fieldprint, by visiting their website at: <http://www.FieldprintWisconsin.com/>. Use the Fieldprint code "FPWIDistributor" when prompted.**
3. **You must submit your application to the Department within 14 days of being fingerprinted.**

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PHARMACY EXAMINING BOARD

WHOLESALE DISTRIBUTOR OF PRESCRIPTION DRUG LICENSE

DESIGNATED REPRESENTATIVE FORM

SECTION A: The Designated Representative listed on the Application (Form #2814) must complete this form.	
Printed Name of Designated Representative <input type="text"/>	
Address of Designated Representative (street, city, state, zip) <input type="text"/>	
Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>	Place of Birth <input type="text"/>
Social Security Number <input type="text"/> - <input type="text"/> - <input type="text"/>	Attach Photo Here (This must be taken within 12 months of the application date.)
Current WI Distributor License # <input type="text"/> -45 or <input type="checkbox"/> New Application (check box if applicable)	

SECTION B: List below places of residence for the last 7-years immediately proceeding the date the application for Distributor is filed.	
1. Address (street, city, state, zip) <input type="text"/>	
Dates Lived at Residence: From: <input type="text"/> / <input type="text"/> / <input type="text"/> To: <input type="text"/> / <input type="text"/> / <input type="text"/>	
2. Address (street, city, state, zip) <input type="text"/>	
Dates Lived at Residence: From: <input type="text"/> / <input type="text"/> / <input type="text"/> To: <input type="text"/> / <input type="text"/> / <input type="text"/>	
3. Address (street, city, state, zip) <input type="text"/>	
Dates Lived at Residence: From: <input type="text"/> / <input type="text"/> / <input type="text"/> To: <input type="text"/> / <input type="text"/> / <input type="text"/>	

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SECTION B: (continued)

4. Address (street, city, state, zip)

Dates Lived at Residence:

From: / / To: / /

5. Address (street, city, state, zip)

Dates Lived at Residence:

From: / / To: / /

6. Address (street, city, state, zip)

Dates Lived at Residence:

From: / / To: / /

7. Address (street, city, state, zip)

Dates Lived at Residence:

From: / / To: / /

SECTION C: List below all occupations, positions of employment and offices held during the last 7-years immediately preceding the date the Distributor application is filed. The employment information listed below must reflect the requirements listed in Wis. State Stats. § 450.071(3) (c).

1. Occupation/Position

Office Held

Name of Business

Dates of Employment:

From: / / To: / /

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SECTION C: (continued)

2. Occupation/Position

Office Held

Name of Business

Dates of Employment:

From: / / To: / /

3. Occupation/Position

Office Held

Name of Business

Dates of Employment:

From: / / To: / /

4. Occupation/Position

Office Held

Name of Business

Dates of Employment:

From: / / To: / /

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SECTION C: (continued)

5. Occupation/Position

Office Held

Name of Business

Dates of Employment:

From: / / To: / /

6. Occupation/Position

Office Held

Name of Business

Dates of Employment:

From: / / To: / /

7. Occupation/Position

Office Held

Name of Business

Dates of Employment:

From: / / To: / /

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SECTION D: (provide answer for each question)

1. Have you been, in the last 7-years proceeding the date the Distributor application filed, the subject of any proceedings for a revocation of any business, or professional license and the disposition of the proceeding?

- Yes
 No

2. Have you been, in the last 7-years proceeding the date the Distributor application filed, enjoined by a court, temporarily or permanently, from either possessing, controlling, or distributing any prescription drug?

- Yes **If yes, provide an attached written description of the circumstances surrounding the injunction.**
 No

3. Have you had any involvement in the past 7-years immediately preceding the date of the Distributor application filed, with any business, including investments other than the ownership of stock in a publicly traded company or mutual fund that manufactured, administered, prescribed, distributed, or stored pharmaceutical products or drugs?

- Yes
 No

4. Have you had any misdemeanor or felony criminal offense, as an adult, that you have been found guilty, adjudication of guilty that was withheld, pleaded guilty or no contest?

- Yes **If yes, provide a written description and indicate if you are appealing this conviction along with a copy of the notice of appeal or the final disposition of the appeal.** (not more than 15 days after the final disposition is reached and attach to this form)
 No

5. I have signed and submitted with this form the Authorization for Release of FBI Information (**Form #2687**) and have contacted Fieldprint for the electronic fingerprint required by statute. If applicant is VAWD accredited the Designated Representative will not need to submit fingerprint cards.

- Yes **My fingerprints were submitted to Fieldprint on:** / /
 No **If no, describe why you are not in compliance with this statute.**

6. I have listed below any other names ever used (e.g., Legal Name Change, Maiden Name, Alias), and particularly, any names I have been arrested under.

7. I have been employed full-time for at least 3-years in a Pharmacy or with a Wholesale Prescription Drug Distributor in a capacity related to the dispensing and distribution of, and record keeping related to, prescription drugs.

- Yes
 No **If no, describe why you are not in compliance with this statute.**

8. I am employed by the applicant full-time in a managerial level position.

- Yes
 No **If no, describe why you are not in compliance with this statute.**

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SECTION D: (provide answer for each question)

9. I am employed by the applicant full-time in a managerial level position.

Yes

No **If no, describe why you are not in compliance with this statute.**

10. I am physically present at the Wholesale Prescription Drug Distributor's facility during regular business hours and am involved in and aware of the daily operation of the Wholesale Prescription Drug Distributor. This subdivision does not preclude the Designated Representative from taking authorized sick leave and vacation time, or from being absent from the facility for other authorized business or personal purposes.

Yes

No **If no, describe why you are not in compliance with this statute.**

11. I am a Designated Representative for only one applicant at any given time. This subdivision does not apply if more than one Wholesale Distributor is located at the facility and the Wholesale Distributors located at the facility are members of an affiliated group.

Yes

No **If no, describe why you are not in compliance with this statute.**

12. I have not been convicted of violating any federal, state, or local law relating to wholesale or retail prescription drug distribution or distribution of a controlled substance.

Yes

No **If no, describe why you are not in compliance with this statute.**

AFFIDAVIT OF DESIGNATED REPRESENTATIVE

The undersigned, having been duly sworn on oath, states that the facts and statements herein contained are true and correct based upon personal knowledge of the undersigned.

Designated Representative Signature:

Date:

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Printed Name of Designated Representative: