

Iowa Board of Pharmacy

Third-Party Logistics Provider (3PL) Facility Manager Change Application Instructions

Once a completed application is received, a fingerprint packet will be sent to the mailing address indicated on the application. The fingerprint packet is to be completed by the facility manager and returned to the Board for processing.

An incomplete application for licensure will only be maintained for a maximum period of 6 months. Failure to submit all required information within 6 months of submission of the original application, including submission of a completed fingerprint packet if required, will result in the application becoming null and void and any fees submitted with the application are forfeited and will not be transferred or refunded.

Submit the completed application, including the instruction check lists, all attachments, and a check in the appropriate amount made payable to the Iowa Board of Pharmacy to:

Iowa Board of Pharmacy
400 SW 8th St. Ste. E
Des Moines, IA 50309

All application fees are non-refundable and non-transferrable.

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| License Change Application Fees – Changes made to the facility manager requires the submission of a completed application and applicable fee(s). | |
| Instate Licensees – The application for license change must be submitted as far in advance as possible prior to the anticipated change. | |
| Nonresident Licensees – The application for license change must be submitted within 10 days of the receipt of an updated license or registration from the home state regulatory authority, the DEA, or the FDA. | |
| 3PL Application Fee | \$750.00 |
| CSAR Fee (if applicable) | \$90.00 |
| Facility Manager Criminal Background Check Fee | \$45.00 |
| Late License Change Application Fees – These fees are due for applications that are not timely submitted, but are submitted within 30 days or required submission period. | |
| 3PL Application and Penalty Fee | \$1500.00 |
| CSAR and Penalty Fee | \$180.00 |
| Facility Manager Criminal Background Check Fee | \$45.00 |
| Reactivation Fee – These fees are due for applications submitted more than 30 days after required submission period. | |
| 3PL Reactivation Fee | \$2000.00 |
| CSAR Reactivation Fee | \$360.00 |
| Facility Manager Criminal Background Check Fee | \$45.00 |

Iowa Board of Pharmacy
 400 S.W. 8th St., Ste. E
 Des Moines, IA 50309-4688
 515-281-5944
<https://pharmacy.iowa.gov>



APPLICATION FOR 3PL FACILITY MANAGER CHANGE

Please type or print legibly in ink. **Incomplete or illegible forms will delay the issuance of your license.**

| APPLICATION CHECKLIST | |
|---|---|
| Facility Manager's Resume | <input type="checkbox"/> YES <input type="checkbox"/> N/A |
| Government Issued Photo ID | <input type="checkbox"/> YES <input type="checkbox"/> N/A |
| List of disciplinary actions taken against any professional or business license not previously reported to the Board and documentation of final disciplinary orders | <input type="checkbox"/> YES <input type="checkbox"/> N/A |
| Explanation and documentation of violation(s) of any federal or state law pertaining to the possession, control, or distribution of prescription drugs not previously reported to the Board | <input type="checkbox"/> YES <input type="checkbox"/> N/A |
| List of each criminal conviction and court records of the conviction(s), and any pending criminal charges not previously reported to the Board | <input type="checkbox"/> YES <input type="checkbox"/> N/A |

| APPLICANT INFORMATION | |
|--|--|
| A. Name of Applicant <i>(name in which company is doing business):</i> | |
| Legal Name: | |
| Federal Tax ID#: | |
| Iowa License Number: | |
| Facility Manger: | |
| NABP e-profile #: | |

If you do not have an NABP e-profile number, you may create one by going to nabp.pharmacy

| B. Facility Address <i>(physical location of establishment which should be reflected on all sales invoices and shipping documents)</i> | | | |
|--|--|-----------------|------------------|
| Street Address: | | Suite #: | |
| Address: | | | |
| City: | | State: | Zip Code: |

The facility phone number must be a direct number to the licensed facility

| | | |
|---------------------|--|---|
| Telephone #: | | Landline <input type="checkbox"/> Cell Phone# <input type="checkbox"/> |
| | | If cell, will you accept text messages? <input type="checkbox"/> Y <input type="checkbox"/> N |

| | | | |
|---|--|---|---|
| Alternate Phone#: | | Landline <input type="checkbox"/> | Cell Phone# <input type="checkbox"/> |
| | | If cell, will you accept text messages? <input type="checkbox"/> Y <input type="checkbox"/> N | |
| Email Address: | | Fax #: | |
| Web Site: | | | |
| Mailing Address (<i>where all correspondence regarding licensure will be sent if other than facility address</i>): | | | |
| Street Address: | | Suite #: | |
| Address: | | | |
| City: | | State: | |
| | | Zip Code: | |

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|----------------------------------|--|
| Effective Date of Change: | |
|----------------------------------|--|

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|--|--|--------------------------------|--|
| FACILITY MANAGER IDENTIFICATION | | | |
| First Name: | | | |
| Middle Name: | | Last Name: | |
| Previous Names Used: | | | |
| Street Address: | | | |
| City: | | State: | |
| | | Zip: | |
| Work Phone: | | | |
| Email Address: | | | |
| Date of Birth: | | Social Security Number: | |

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| PERSONAL ATTESTATION QUESTIONS | |
| Initial each statement to indicate your understanding and agreement to abide by applicable federal and state laws governing wholesale distribution and logistics services. | |
| | I have adequate experience in providing or coordinating warehousing or other logistics services of products. |
| | I am employed by the applicant full-time in a managerial level position. |
| | I am actively involved in, and aware of, the daily operation of the facility |
| | I am physically present, except for an authorized absence such as sick or vacation leave, at the facility of the applicant during regular business hours. |
| | I do not have any felony convictions or convictions related to prescription drug and device distribution, including distribution of controlled substances, under federal, state, or local laws. |
| | I have knowledge and understanding of federal and states laws, rules, and regulations pertaining to drug and device distribution. |

| ADDITIONAL QUESTIONS | |
|--|-------------|
| If you answer "YES" to any question, please attach supporting documentation. Failure to provide complete and correct information may result in delay or denial of your third party logistics application. | |
| 1. Have you had disciplinary action taken against any professional or business license you have held? If yes, provide copies of any final disciplinary orders. | YES NO |
| 2. Have you been enjoined, either temporarily or permanently, by a court of competent jurisdiction for violating any federal or state law regulating the possession, control, or distribution of prescription drugs? If yes, documentation regarding the event. | YES NO |
| 3. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime other than a minor traffic offense, in any jurisdiction? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. (For example, you must report if your conviction was expunged, you receive a deferred judgment, or you received an executive pardon.) If yes, provide court records of the conviction(s). | YES NO |
| 4. Do you have any pending criminal charges? If yes, copies of any pending charges. | YES NO |

*** Nolo contendere- A plea in a criminal case which has a similar legal effect as pleading guilty. The defendant does not admit or deny the charges, but a fine or sentence may be imposed based on this plea.*

| FACILITY MANAGER SIGNATURE | |
|---|--|
| By signing this application, I solemnly affirm under the penalty of perjury that the contents of this section of the application are true to the best of my knowledge, information, and belief. I understand that the Iowa 3PL license issued pursuant to this application may be revoked if any assertion made in this application is found to be false. | |
| Printed Name: | |
| Signature: | |
| Date: | |

| LICENSEE SIGNATURE | |
|--|--|
| I hereby swear or affirm under penalty of perjury that the information provided in this application is true and correct. I understand that failure to provide complete and truthful information may constitute grounds for denial, revocation, or other disciplinary sanctions against my license. | |
| Signature of Applicant: | |
| Date: | |
| Printed Name and Title: | |

Privacy Act Notice: Disclosure of your Social Security number on this application is required by 42 U.S.C. § 666(a)(13) and Iowa Code §§ 252J.8(1), 261.126(1), and 272D.8(1). The number will be used in connection with the collection of child support obligations, college student loan obligations, and debts owed to the state of Iowa, and as an internal means to accurately identify registrants, and may be shared with taxing authorities as allowed by law including Iowa Code § 421.18.