Pharmacy Check List:

-Initial

____Application;
____Application nonrefundable fee of $200 payable to "**CNMI TREASURER**";
____The name, address, and contact information of the individual requesting the license;
____The name(s) under which the applicant does business;
____The name of the Pharmacist-in-Charge of the facility to be licensed;
____A copy of the Commonwealth license for the applicants Pharmacist in Charge;
____The names and contact information of all of the individual owners and/or corporate officers;
____If the applicant is a corporation, a copy of the corporation's articles of incorporation and a letter of good standing from the jurisdiction of incorporation;
____A copy of the applicants Commonwealth business license;
____A statement by all of the owners, corporate officers, pharmacists, technical staff, and any other individual with decision making responsibilities, stating whether:

- they have been arrested or involved in litigation and/or arbitration;
- have ever had their professional license disciplined for any reason;
- ever had a denial of a personal license, permit, certificate, or registration for a privileged, occupational, or professional activity;
- denials of a business or industry license or related finding of suitability, or participation in a group that has been denied a business or industry license or related finding of suitability;
- Administrative actions or proceedings related to the pharmaceutical industry or participation in a group that has been the subject of such administrative actions or proceedings;
- guilty findings or pleadings or pleas of nolo contendere to any offense, federal or state, related to prescription Drugs and/or controlled substances or participation in a group that has been found or pled guilty or that has pled nolo contendere to any such offense;
- surrender, voluntary or otherwise, of licensure, permit, or certificate of registration relating to the pharmaceutical industry, or participation in a group that has surrendered, voluntary or otherwise, any such licensure, permit, or certificate of registration;

____A map showing the physical location of the pharmacy;
____A floor plan of the pharmacy showing the essential areas for appropriately securing pharmaceutical products, securing controlled substances, compounding area, private patient counseling area, and prescription preparation area.

-Renewal

____Renewal application
____Copy of CNMI License for Pharmacist in Charge
____Copy of Annual Corporation Report
____Copy of all current CNMI Mandatory CNMI permits (sanitary, occupancy, fire inspection, etc…)
____Signed Statement by all of the owners, corporate officers, pharmacists, technical staff and any other individual with decision making responsibilities
____Renewal fee of $300 payable to "**CNMI TREASURER**"

-Schedule of Fees

Application fee	$200
Initial license fee	$300
Renewal fee	$300
Delinquent fee (charged every 1st of the month after expiration date)	$25
Replacement/Duplication of license	$75
Replacement/Duplication of wallet size card	$25
Letter of Good Standing/Verification fee	$25

Commonwealth of the Northern Mariana Islands
HEALTH CARE PROFESSIONS LICENSING BOARD
P.O. Box 502078, Bldg., 11925 Pohnpei Court
Capitol Hill, Saipan, MP 96950
Tel No: (670) 664-4809 Fax: (670) 664-4814
Email: info@cnmilicensing.gov.mp
Website: www.cnmilicensing.gov.mp

PHARMACY APPLICATION

APPLICANT, PLEASE NOTE: EVERY PERMIT UNDER THIS AUTHORITY SHALL BE DEEMED TO BE PERSONAL AND MAY NOT IN ANY CIRCUMSTANCES BE TRANSFERRED TO ANY OTHER PERSON. A SEPARATE APPLICATION MUST BE FILED FOR EACH PERMIT. THERE MUST BE A PERMIT FOR EACH SEPARATE BUSINESS LOCATION.

1. FULL NAME OF APPLICANT | **DOING BUSINESS AS** (Business name as advertised)

	Complete Name of Business:

2. BUSINESS MAILING ADDRESS | **BUSINESS LOCATION (Physical Address)**

P.O. Box or Street No.:	Street No. or Village:

3. TYPE OF FIRM (check and complete one)

Business Phone No.:	Hours of Operation:

_____A. CORPORATION **Please check mark**

Is Business a foreign corporation?	Yes		No	
Is it registered under the law of the CNMI	Yes		No	
Is it registered under the law of the United States	Yes		No	
If "yes" which state:	Date of Incorporation:			

_____B. PARTNERSHIP (List name and address of each partner)

1. Last:	First:	Middle:	Address:
2. Last:	First:	Middle:	Address:
3. Last:	First:	Middle:	Address:

_____C. SOLE PROPRIETOR

_____D. OTHER (SPECIFY)

4. AGENT FOR SERVICE – Agent authorized to accept services of process in legal proceeding against the Corporation

Name of Agent:	
Title of Agent:	
Local Address of Agent:	

5. Federal Tax ID Number | **CNMI Tax ID Number**

6. Authorized Representative

Name:	Phone Number:	Fax Number:
Mailing Address:		e-Mail:

7. DEA

DEA No:	Expiration:

8. APPLICATION TYPE

New		Renewal		Change of Location		Change of Ownership	

9. TYPE OF PHARMACY LICENSE

Wholesale		Hospital		Community/Retail		Mail – Order	

10. SUB-TYPE – if applicable

Nuclear		Remote Dispensing Site		Tele-Pharmacy		Specialty	

11. COORDINATING PHARMACY – (Remote Dispensing Site or Tele-Pharmacy Only)

Name:		CNMI License No.:		Expires:
Address:	City:		State:	Zip Code:
On-Site Certified Pharmacy Technician		CNMI License No.:		Expires:
Contact Number:	E-Mail:		Visual Check System or Software **(Tele-Pharmacy Only)**	

12. STATE OF LICENSURE for FACILITY (Non-Residents Only)

License No.:	Expiration:

13. PHARMACIST IN CHARGE

Name:	State of Licensure:	License Number:	Expiration:
Contact Number:	E-Mail:		

14. OWNERSHIP – List names and titles of all owners, Corporate Officers, Managers, Partners or Members
Attach additional sheets if necessary

Name	Address	Phone Number	Title
1.			
2.			
3.			
4.			
5.			

15. BACKGROUND **Please check mark**

Have any applicants, partners, or managers had a suspension, revocation, or restriction of a professional license? If "Yes", please list and explain on a separate sheet of paper.	Yes		No	
Have any applicants, partners, or managers been found guilty of a drug or controlled substance violation? If "Yes", please list and explain on a separate sheer of paper.	Yes		No	

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Name and Signature of Authorized Person _____ Title _____ Date