GOVERNMENT OF THE VIRGIN ISLANDS
DEPARTMENT OF HEALTH
OFFICE OF PROFESSIONAL LICENSURE AND HEALTH PLANNING (PLHP)

VIRGIN ISLANDS BOARD OF PHARMACY

Revised 03/09/2022

REGISTRATION APPLICATION TO SHIP MEDICATIONS TO THE UNITED STATES VIRGIN ISLANDS

PLEASE TYPE: **PLEASE CHECK ONE: PHARMACY WHOLESALER DISTRIBUTOR**

Pharmacy Name:	State License Number:	License Expiration Date:

Physical Address of Pharmacy:

Mailing Address of Pharmacy *(if different from Physical Address:)*

Pharmacy Website:	Pharmacy Phone Number:

Pharmacy DEA Number:	Expiration Date:	Pharmacy Fax Number:

Check all appropriate categories of medications that will be shipped:

☐ C-II ☐ C-III ☐ C-IV ☐ C-V ☐ Non-controlled legend

☐ OTC ☐ Herbal ☐ Other *(specify)* :____

Check all appropriate:

☐ Compounded Sterile Products:
- ☐ Injectable/IV
- ☐ Ophthalmic
- ☐ Other (specify) _______________

☐ Non-sterile Compounded Products:
- ☐ Oral
- ☐ Topical
- ☐ Other (specify) _________________

☐ Commercially manufactured products

List the names of prescribers licensed to practice in the U.S. Virgin Islands that the products will be shipped to:

____

____

List all states that your pharmacy is currently allowed to ship to:

____

____

Within the last 5 years, were there any deficiencies noted by the State Board of Pharmacy? ☐ Yes ☐ No
If yes, explain: (use separate sheet if additional space is needed)

____

BACKGROUND INFORMATION - CURRENT PHARMACIST- IN-CHARGE

P.I.C/P.O.R. / Manager Name: (First Middle Last)	State License Number:	License Expiration Date:

Email Address:	Telephone Number:

Have you ever underwent a disciplinary hearing? ☐ Yes ☐ No
If yes, explain *(use separate sheet if additional space is needed)*

____

Have you ever been convicted of a felony or misdemeanor? Yes No

If yes, explain (use separate sheet if additional space is needed)

Have you ever been involved in a malpractice settlement? Yes No

If yes:

How many? ____________________ For what?____

What was the award?________________________________What was the settlement? _____________________________

PROGRAM REQUIREMENTS

By completing this registration form the applicant agrees to:

1. Notify the Virgin Islands Board of Pharmacy (V.I.B.O.P) when there is any change in P.I.C. within 10 business days.
2. Notify the V.I.B.O.P. in the event of changes in the pharmacy ownership within 10 business days .
3. Provide the V.I.B.O.P. with a current state pharmacy license, each time it is renewed.
4. Provide the V.I.B.O.P with a copy of current liability insurance and proof that coverage includes products shipped to the U.S Virgin Islands, each time it is renewed.
5. Comply with and in accordance to FEDERAL REGULATIONS UNDER 21 U.S.C.. 801-971 or any other regulation applicable to the activities being performed
6. Notify the V.I.B.O.P. of any changes shipping activities to the U.S.V.I. provided above including, but not limited to: additional prescribers, change in pharmacy location, schedules/categories of products shipped within 10 business days.
7. Ensure that only federally approved medications for use in the United States will be shipped.
8. Once completed, mail this original registration form along with:
   1. Copy of current state pharmacy license;
   2. Copy of P.I.C. pharmacist license;
   3. Copy of DEA registration;
   4. $936.00 Application fee payable to "Government of the VI";
   5. Copy of pharmacy's certificate of liability insurance;
   6. Copy of state board inspection report & corrective measures if deficiencies are noted; and
   7. Attach cover letter with name, email & telephone # for individual who can address questions regarding this registration application.

Mail to: **VI Board of Pharmacy - PLHP**
PO Box 222995
Christiansted, VI 00822-2995

AFFIRMATION STATEMENT

I hereby affirm under the penalties of perjury that the statements made in this registration application are true, complete and correct. I waive, for processing of this application, any confidential provisions concerning the information required to be provided.

I further understand that non-compliance with any of the program requirements outlined above may result in revocation of our being allowed to ship medications into the U.S.V.I.

Applicant: ____

Print Sign Date:

Witness: ____

Print Sign *Notary Seal*

Notary Public:

____

My commission expires:

Print Sign Date:

IMPORTANT:

Shipping of products to the Virgin Islands can proceed only after written approval from the V.I.B.O.P..03/09/2022