VIRGIN ISLANDS BOARD OF PHARMACY

P.O. Box 222995
Christiansted, VI 00822-2995
Tel: 340-643-8992
Email: BoardofPharmacy@doh.vi.gov

FILLABLE APPLICATION
PLEASE TYPE

REGISTRATION APPLICATION TO SHIP MEDICATIONS TO THE UNITED STATES VIRGIN ISLANDS

CHECK ONE: ❑ **INITIAL APPLICATION** ❑ **RENEWAL APPLICATION**

CHECK ONE: ❑**CENTRALIZED SERVICES** ❑**PHARMACY** ❑**WHOLESALER** ❑**DISTRIBUTOR**

Pharmacy Name:	State License Number:	License Expiration Date:
Virgin Islands License Number:	Virgin Islands 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 the states that the 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 a separate sheet if additional space is needed and attach corrective measures)*

BACKGROUND INFORMATION – CURRENT PHARMACIST IN CHARGE

CHECK ONE: ❑ **P.I.C** ❑ **P.O.R.** ❑ **Manager** Name: (First Middle Last)	P.I.C. License Number:	P.I.C. License Expiration Date:
Email Address:	Telephone Number (Direct):	

Have you ever underwent a disciplinary hearing? ❑ Yes ❑ No ❑ N/A
If yes, explain (use a 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
P.O. Box 222995
Christiansted, VI 00822-2995

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NON-RESIDENT PHARMACY 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 Public: _____ _____
Print Sign

My Commission Expires: _____ *Notary Seal*

IMPORTANT:

Shipping of products to the U.S. Virgin Islands can proceed only after written approval from the Virgin Islands Board of Pharmacy.