Capital Wholesale Drug Company
Controlled Information Survey (CIS)

Sales Rep Name: _____

Customer Account Name: _____

Customer Address: _____

City/State/Zip _____

Customer Account Number:

Reviewed by Capital Wholesale Drug Company

Accepted_____ Declined_____

_____ _____

(Signature) (Date)

Please FAX the completed Compliance Information Survey and STATE and DEA LICENSES

Fax survey to 1-800-536-9686 Cincinnati or 614-297-8224 Columbus

State and Federal Compliance Information Survey must be completed and faxed back before any controlled substances will be shipped.

To ensure compliance with requirements of individual state licensing boards and to ensure compliance with the requirements of the Code of Federal Regulations on the sale of Controlled Substances, Capital Wholesale Drug Company must perform due diligence on each customer where prescription and/or controlled substances are purchased. We ask that you complete the below questionnaire, attach information where requested and return the information. All information will be held in strict confidence. Some categories of controlled substances may have restricted quantities and are shipped pending Compliance Review.

Section I - State Governing Board and Licensing Information	
1. State of Licensure and type of license, e.g., pharmacy, practitioner, wholesaler, hospital/clinic, etc.	
2. Enter your state license number and expiration date. Do not forget to attach a copy of your current state license.	
3. At any time in the last 5 years have you been inspected by a state governing board, the State Board of Pharmacy or Medical Board? If yes, provide a separate sheet of paper stating the results of this inspection and corrective actions taken.	
4. Are you currently under investigation by the Board of Pharmacy or Medical Board or any state governing board? If yes, provide a synopsis of the investigation on a separate sheet of paper.	
5. Have you or your company or business ever had a license denied, revoked or suspended by any state governing board? If yes, attach a separate sheet of paper stating the reason(s) for any of these actions.	

Section II - General Compliance and Business Information	
1. Provide the name of the employee that is directly responsible for ensuring that prescription drugs and/or controlled substances are adequately safeguarded in accordance with state and federal regulations. This person is normally the Pharmacist in Charge, Medical Practitioner or Designated Representative.	
2. Provide the area code and telephone number of the employee listed above.	

3. Provide the name of the employee or purchasing agent that is responsible for the purchasing of prescription drugs and controlled substances. If these are two separate employees then enter the name of each employee along with area code and telephone number for direct contact.	
4. Indicate the number of years you have been in business at this location.	
5. Has there been any change in ownership of this business within the last 5 years?	
6. Do you resell any prescription drugs or controlled substances to other wholesale distributors or pharmacies? If yes, you must attach a listing of these customers along with addresses and telephone numbers.	
7. Do you fill scripts for Pain Management Clinics or Pain Management Physicians? If yes, please list.	
8. Do you own any part of any other Healthcare related businesses? If yes, please list.	
9. Do you fill out of State prescriptions?	
10. Do you operate an Internet Site that offers the sale of Pharmaceutical products (prescription drugs and/or controlled substances) to the general public? If Yes, indicate the website address and the number of years you have operated this website.	
11. If you operate a website that offers the sale of pharmaceutical products to the general public you must attach a copy of your Verified Internet Pharmacy Practice Site (VIPPS) Accreditation or Verified Accredited Wholesale Distributor (VAWD) Accreditation	

Section III - Controlled Substance Registration Information	
1. Federal DEA Number and expiration Do not forget to attach a copy of Current DEA license	
2. Business name and/or name of individual as it appears on your Federal DEA controlled substance registration certificate	
3.License Type. For example: Retail Pharmacy, Practitioner, Distributor, Hospital/Clinic	
4. Name of the person that signed the original application for the registration and/or the most recent renewal submitted to the DEA.	
5. Name of the person authorized to execute (sign) the DEA 222 Form	
6. We reserve the right to ask for a Power of Attorney at any time another person executes a DEA Form 222 in your behalf.	
7. Are you currently under investigation by the DEA ,if yes please provide information.	
8.Have you been investigated or inspected by the DEA in the last five years, if yes please provide information of investigation and the corrective actions taken.	
9. Have you or your company or business ever had a controlled substance registration denied, revoked or suspended for cause? If yes, attach a synopsis of this action on a separate sheet of paper.	

10. For controlled substance sales, you MUST indicate below all types of customers that purchase controlled substances from your business. Please circle yes or no and provide notes if needed.			
Dispensing to End User	Yes	No	
Diet Clinics	Yes	No	
Emergency Clinics	Yes	No	
Government Agencies	Yes	No	
Hospice Patients	Yes	No	
Hospice Pharmacies	Yes	No	
Hospitals	Yes	No	
Internet Pharmacies	Yes	No	
Mail Order	Yes	No	
Nursing Homes/Assisted Living	Yes	No	
Pain Clinics	Yes	No	
Pharmacies	Yes	No	
Physicians	Yes	No	
Wholesale Distributors	Yes	No	
OTHER --Please indicate	Yes	No	

Please attach a copy of your policy and procedure plan for handling and dispensing controlled substances

We thank you for furnishing the information above and for attaching the supporting documentation as requested.

If you have questions, please contact James Bergados ph. (614) 297-8225 fax (614) 297-8224

Your signature is required below.

I certify under penalty of perjury that the forgoing information is true and correct. I also agree to contact Capital Wholesale Drug Company if there is any change in the regulatory status of this business such as a change in licensure or ownership.

_____ _____

(Signature of person identified in section II, question 1) **(Date)**

_____

(Print name)