CAPITAL DRUG
Est. 1950

Capital Wholesale Drug Company
873 Williams Avenue
Columbus, OH 43212
https://www.capital-drug.com

Compliance Department
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Customer Information Survey (CIS)

Pharmacy Initial Application

For Internal use only	*CS Approvals:*					
Accepted ☐	*Gabapentin*	*Y / N*	*Class III*	*Y / N*	*Class IV*	*Y / N*
Declined ☐	*Butalbital*	*Y / N*	*Class III-N*	*Y / N*	*Class V*	*Y / N*
Signature _____			*Date* _____			

Name of Business: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Email: _____
Sales Rep: _____ Customer Account Number: _____

Section 1: Business Information

CONTACT INFORMATION		
	Name	**Phone and/or Email**
Pharmacist in Charge (PIC)		
Controlled Substance Purchaser		

LICENSE AND REGISTRATION INFORMATION (N/A if license type is not applicable)		
License Type	**License Number**	**Expiration Date**
State License		
State Controlled Substance License		
DEA Registration		
PIC License		

1. Business hours of operation: _____
2. Business Type (Retail, Mail order, Closed Door-LTC, etc.): _____
3. How long has your business been in operation under the current state license? _____
4. Is your business affiliated with any other pharmacy? ☐ Yes ☐ No
   If yes, please provide the name(s): _____
5. Has your business ever operated under a different name? ☐ Yes ☐ No
   If yes, please provide the name(s): _____
6. Date of last inspection by:
   a. State Board of Pharmacy: _____ b. DEA: _____
   c. Were there any findings and/or was corrective action required? ☐ Yes ☐ No
7. Have you, the pharmacy, owners, PIC, or DR ever been investigated or disciplined OR are you currently being investigated by a state governing board or the DEA? ☐ Yes ☐ No

8. Have you ever had a license or DEA registration denied, revoked, voluntarily surrendered, or suspended by any state governing board or the DEA? ☐ Yes ☐ No
9. Has any owner or employee of your business/facility ever been arrested or convicted of any misdemeanor or felony pertaining to distribution, manufacturing, sale, or dispensing of drugs, controlled substances, or narcotics? ☐ Yes ☐ No
10. If you answered yes to any of questions 4 through 9, please provide additional details and any corrective action completed. (Include attachments if needed):

_____

_____

_____

11. Do you resell or transfer any prescription drugs or controlled substances? ☐ Yes ☐ No
    If yes, please provide percentage of products sold or transferred: _____
12. Do you operate an internet website that offers the sale of prescription pharmaceutical products to the public? ☐ Yes ☐ No
    If yes, indicate the website address and number of years in operation. Please attach a copy of your VIPPS accreditation. _____
13. Identify current security measures: Security Cameras Alarm System Pharmacy Barricade
    Other: _____

Section 2: Controlled Substance Information (Skip to section 3 if you do not want to purchase CS from Capital)

14. Do you purchase controlled substances from distributors other than Capital Drug? ☐ Yes ☐ No
    If yes, list your primary distributor followed by all others: _____
    _____
15. List the name of the person who signed the most recent DEA application/renewal:
    _____
16. Do you fill prescriptions for controlled substances for any of the following?
    a. Patients that are outside your state? ☐ Yes ☐ No
       If yes, list the state and number of prescriptions: _____
    b. Patients receiving pain management treatment? ☐ Yes ☐ No
    c. Patients receiving medication assisted treatment for Substance Use Disorder? ☐ Yes ☐ No
    d. Patients from Bariatric/weight-loss clinics and/or prescribers? ☐ Yes ☐ No
    e. Other specialized patient populations? ☐ Yes ☐ No
       If yes, please describe (ex - hospice, hospitals, pets, 340B, etc.): _____
    _____
17. Do you report to the state PDMPs in which you are licensed as required? ☐ Yes ☐ No
    If yes, how often do you report? _____
18. Do you check your patients' profiles in your state's PDMP? ☐ Yes ☐ No
    If yes, how often? _____
19. On average, how many non-controlled and controlled prescriptions are dispensed by your business/facility daily?
    Non-controlled: _____ Controlled: _____
20. Inventory Information

	How often is inventory counted?	**Date of Last Inventory Count**
Controlled Substance		
Non-Controlled Substances		

21. Fill in the chart below with the average number of prescriptions dispensed daily per payment method.

	Cash, Debit, Credit, or Check:	Medicare or Medicaid:	Insurance:	Workman's Compensation:	Other:
Controlled Substances					
Non-Controlled Substances					

22. Provide your top ten controlled substance prescribers and their DEA Registration number:

Prescriber Name	DEA Registration Number	Prescriber Name	DEA Registration Number
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Section 3: Documentation Needed

**Please include the following documentation with your completed application:*

- ☐ 90 day dispense report for ALL prescriptions dispensed (Controlled Substances and Non-Controlled) including: Date range, Drug name, NDC, total Rx count and total quantity in Microsoft Excel format
- ☐ Current Controlled Substance Procedures
- ☐ Most recent inspection report with corrective action, if applicable
- ☐ Current DEA License
- ☐ Current State License
- ☐ Current State Controlled Substance License *(if applicable)*
- ☐ Current PIC License
- ☐ Any Current Out of State License *(if applicable)*

Section 4: Declaration

- I will follow all applicable federal and state laws and regulations regarding the dispensing and sale of prescription medication.
- I will only provide controlled substances to patients with a legitimate prescription for a legitimate medical purpose or to DEA registered entities.
- I agree to notify Capital Wholesale Drug Company immediately if the practitioner/license holder responsible for this business/facility leaves the practice or if a change in ownership occurs.
- I agree to notify Capital Wholesale Drug Company immediately if there is a change in the licensure status of the business/facility.

I certify, under penalty of perjury, that the above information is true and correct.

Owner/Practitioner/License Holder

Signature: _____ Date: _____

Printed Name: _____

Title: _____

Business/Facility Name: _____