NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Parkway, Suite 206 - Reno, NV 89521 - (775) 850-1440

Wholesaler Application

Non-Refundable $1,000 Fee

This application cannot be returned by fax or email.
We must have an original signature and fee to process.

NRS 639.016 "Wholesaler" defined. "Wholesaler" means a wholesale distributor as defined by 21 C.F.R. § 205.3(g) who supplies or distributes drugs, medicines or chemicals or devices or appliances that are restricted by federal law to sale by or on the order of a physician to a person other than the consumer or patient. The term includes a person who derives, produces, prepares or repackages drugs, medicines or chemicals or devices or appliances that are restricted by federal law to sale by or on the order of a physician on sales orders for resale. The term does not include a nonprofit cooperative agricultural organization which supplies or distributes veterinary drugs and medicines only to its own members.

NRS 639.009 "Manufacturer" defined. "Manufacturer" means a person who:

1. Derives, produces, prepares, compounds, mixes, cultivates, grows or processes any drug or medicine;
2. Repackages any drug or medicine for the purposes of resale; or
3. Produces or makes any devices or appliances that are restricted by federal law to sale by or on the order of a physician.

NAC 639.6937 "Medical products wholesaler" defined.

1. "Medical products wholesaler" means a person licensed as a wholesaler pursuant to chapter 639 of NRS who sells, leases or otherwise provides medical products to a health care facility, agency, practitioner or provider in this State.
2. The term does not include:
   (a) A person who sells, leases or otherwise provides medical products to a consumer; or
   (b) An installer of medical gas systems, as that term is defined in NAC 477.137, who is registered pursuant to chapter 477 of NAC.

NAC 639.6935 "Medical products" defined.

1. "Medical products" includes medical devices, equipment, supplies and gases intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease.
2. The term does not include:
   (a) Controlled substances;
   (b) Dangerous drugs, except medical gases and supplies that facilitate the use of a dangerous drug, including, without limitation, normal saline and other similar inert liquids;
   (c) Medical devices, equipment, supplies or gases the regulation of which is governed by any other board or agency other than the Board; and
   (d) Pressurized stockings that have a pressure rating of less than 20 millimeters of mercury.

Print and mail the completed application with a **non-refundable fee** of $1,000.00 paid for by credit or debit card or a check made payable to the **Nevada State Board of Pharmacy**. Credit and debit card payments are charged a **5% processing fee**. Send the completed application to the address indicated on top of this application.

All incomplete applications will be returned. Please ensure all requirements of the application are completed before submission. The deadline date for an application to be considered during a particular board meeting is posted on our website. If a completed application is not received by our office by the deadline, the application will not be considered until the next scheduled board meeting. **Please note that an application received just prior to the deadline date does not guarantee placement on the board agenda.** Upon receipt of a completed application, the application will be placed on the agenda of the next regularly scheduled Board meeting. For application deadlines and meeting schedule please visit bop.nv.gov.

If you have any questions, please contact the Nevada State Board of Pharmacy at 775-850-1440.

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Where is the facility located?		☐ Nevada ☐ Out-of-State
Type of Application (check applicable box)		**Wholesaler Business Type (check applicable box)**
☐ New Wholesaler ☐ Ownership Change* ☐ Name Change* ☐ Location Change* (in-state only)	* If making a change, provide current license number: WH _____	☐ Publicly Traded (complete sections 1, 2, 3, 4, 5, 9, 10) ☐ Non-Publicly Traded (complete sections 1, 2, 3, 4, 6, 9, 10) ☐ Partnership (complete sections 1, 2, 3, 4, 7, 9, 10) ☐ Sole Owner (complete sections 1, 2, 3, 4, 8, 9, 10)

Section 1: General Information

Facility Name: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different from physical address): _____

City: _____ State: _____ Zip: _____

Telephone: _____ Website: _____

Name of Designated Representative (DR):_____

Licensing Company Email: _____ DR Email: _____

Entities the Wholesaler will Serve (✓ all applicable)	**Products to be Handled or Wholesaled (✓ all applicable)**	**Type of Wholesaling (✓ all applicable)**
☐ Pharmacies ☐ Practitioners ☐ Hospitals ☐ Wholesalers ☐ Veterinarians ☐ Others:	☐ Dangerous Drugs ☐ Controlled Substances ☐ [a]Medical Products (medical devices, equipment, supplies, gases) ☐ Others:	☐ Manufacturer ☐ Repacker ☐ Reverse Distributor ☐ Warehouse ☐ Retail pharmacy wholesale distributor ☐ Others:

Section 2: ONLY COMPLETE THIS SECTION IF THE COMPANY IS WHOLESALING [a]Medical Products (medical devices, equipment, supplies and gases). Are any of the owners a health professional (i.e. Practitioner as defined by NRS 639.0125, Advanced Practice Registered Nurse, Physician's Assistant, Physical Therapist, Occupational Therapist, Registered Nurse, Respiratory Therapist, etc.)? If yes, please provide the name of the owner, their credentials and their percent ownership. (NAC 639.6943, NAC 693.6933)

Name: _____ Credentials: _____ %: _____

Name: _____ Credentials: _____ %: _____

Name: _____ Credentials: _____ %: _____

Name: _____ Credentials: _____ %: _____

Name: _____ Credentials: _____ %: _____

1. The Board will not issue a license to conduct business as a medical products provider or medical products wholesaler to:

   a) A practicing health professional; or

   b) A partnership, corporation or association in which a practicing health professional has a controlling interest or in which ownership of 10 percent or more of the available stock is held by one or more practicing health professionals.

2. As used in this section, "practicing health professional" means a health professional who performs services within the scope of his or her licensure or registration in any capacity in a health care facility other than the facility of the medical products provider or medical products wholesaler.

Section 3: History of Company	**Yes**	**No**
1. Has the corporation, any owner(s), shareholder(s) or partner(s) with at least 10% interest or partners with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)?		
2. Has the corporation, any owner(s), shareholder(s) or partner(s) with at least 10% interest or partners with any interest, ever been denied a license, permit or certificate of registration?		
3. Has the corporation, any owner(s), shareholder(s) or partner(s) with at least 10% interest or partners with any interest, ever been subject of an administrative action or proceeding relating to the pharmaceutical industry?		
4. Has the corporation, any owner(s), shareholder(s) or partner(s) with at least 10% interest or partners with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances?		
5. Has the corporation, any owner(s), shareholder(s) or partner(s) with at least 10% interest or partners with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)?		

Please use and make copies of this page (if necessary) to provide information regarding any questions, 1-5, you have marked "YES" to in section 3 of the application. A signed statement of explanation for each event and a copy of all documents that identify the circumstance or contain an order, agreement or other disposition for the event must be provided.

This is in response to Question # _____. Provide all the following *where applicable*:

Date of Event/Arrest	Disposition Date	State	City	County

Case #	Governing, licensing, Arresting Presiding Body/Agency/Court

Reason/Charge

Plaintiff/Defendant/Claimant/Respondent	Lawsuit/Arbitration/Bankruptcy

Name of Business/Industry/Entity

Provide explanation below:

Original Signature (electronic, copies or stamps not accepted)

Date

Section 4: List the top four suppliers your company has been associated with in regards to pharmaceutical products that were sold, dispensed or distributed within the last year.

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Section 5: Publicly Traded Corporation

State of Incorporation: _____

Parent Company (if any): _____

Corporation Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

Contact Person Name: _____

Date of SEC Registration:	SEC Registration Number:	Stock Exchange Symbol:

Section 6: Non-Publicly Traded Corporation or Company

State of Incorporation/Organization: _____

Parent Company (if any): _____

Corporation/Organization Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

Contact Person Name: _____

Section 7: Partnership

Partnership Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

Contact Person Name: _____

Section 8: Sole Owner

Owner's Name: _____

Business Name: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

I certify under penalty of perjury that the information contained in this application is accurate, true and complete in all material respects. I understand that making any false representation in this application is a crime under NRS 639.281. I understand that, pursuant to NRS 239.010, this entire application and any portion thereof is a public record unless otherwise declared confidential by law, and will be considered by the Nevada State Board of Pharmacy at a public meeting pursuant to NRS 241.020. In the event this application is approved I agree to comply with all applicable federal and state statutes and regulations governing this license or registration and understand that any violation may result in discipline. I further certify compliance with NRS 639.590 and NAC 639.594 as applicable.

_____

Facility Name

_____

Print Name of Authorized Person Submitting Application

_____ _____

Original signature of Authorized Person (copies or stamps not accepted) Date

Board Use Only	Date Received: _____ Amount: _____

Section 9: NABP Accreditation/FDA Registration	Yes	No
Is your company Drug Distributor or VAWD Accredited by NABP? If yes, provide:		
1. Copy of Certification 2. Copy of a bond in an amount of $25,000 made payable to the state of Nevada. This must be current to maintain a Nevada wholesaler registration. Complete the **Surety Bond form** at http://bop.nv.gov/Services/newapps/Business/.		
Is your company licensed as a Manufacturer by the FDA? If yes, provide:		
1. Copy of FDA registration 2. Copy of a bond in an amount of $25,000 made payable to the state of Nevada. This must be current to maintain a Nevada wholesaler registration. Complete the **Surety Bond form** at http://bop.nv.gov/Services/newapps/Business/.		

Section 10: Provide the following documents with your application based on your Business Type. Required documents are indicated by an "✓" on the right.	Publicly Traded	Non-publicly Traded	Partner-ship	Sole Owner
• **List of all Officers and Directors.**	✓	✓		
• **List the top four corporation shareholders and their percent ownership.**	✓			
• **List of all corporation shareholders and their percent ownership.**		✓		
• **List of all partners and their percent ownership.**			✓	
• **Certificate of Corporate Status or Certificate of Good Standing** obtained from the Secretary of State's Office in the State where the business is domiciled, dated within the last **12 months**.	✓	✓	✓	✓
• **Designated Representative form** must be completed by the Designated Representative. Access form at http://bop.nv.gov/Services/newapps/Business/		✓	✓	✓
• **Personal History Record Application** must be completed by each shareholder/stockholder/partner/owner owning more than 10% of the business stocks/shares. Access form at http://bop.nv.gov/Services/newapps/Business/		✓	✓	✓
• **Copy of DEA certificate if handling controlled substances**	✓	✓	✓	✓
• **Copy of current SEC 10K or 8K** (First 15 pages only)	✓			
• **List containing each employee, agent, independent contractor, consultant, guardian, personal representative, lender or holder of indebtedness of the applicant.**	✓	✓	✓	✓
• **Copy of your license, certification, permit or registration issued to your wholesaler business** from the regulatory board or licensing authority of the state or territory in which the wholesaler is located. **(REQUIRED FOR OUT-OF-STATE WHOLESALERS, if applicable)**	✓	✓	✓	✓
• [a]**Medical Devices, Equipment and Gases (MDEG) Administrator form** must be completed if the business will wholesale [a]Medical Products (medical devices, equipment, supplies, gases). (NAC 639.6957). Access form at https://bop.nv.gov/Services/newapps/Business/	✓	✓	✓	✓
• **If providing [a]Medical Products (medical devices, equipment, supplies, gases), supply a copy of proof of insurance (NAC 639.6957).** The Medical Products wholesaler shall maintain liability insurance of at least one million dollars ($1,000,000.00).	✓	✓	✓	✓
ONLY Complete below if your company is NOT accredited by NABP and/or FDA registered (see Section 9)				
• **Submit Fingerprints** following instructions found at: https://www.bop.nv.gov/siteassets/content/services/newapps/fp-instructions-nrs-639.500---effective-9.17.2026--wh.pdf.		✓	✓	✓
• **Copy of a bond in an amount of $100,000** made payable only to the State of Nevada. This must be current to maintain a Nevada Wholesaler registration. Complete the **Surety Bond form** at: http://bop.nv.gov/Services/newapps/Business/.		✓	✓	✓

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(775) 850-1440 • 1-800-364-2081 • FAX (775) 850-1444

• Web Page: bop.nv.gov

Applicant Name: _____

Payment: Pay application fee by providing your credit or debit card information below, or by submitting a check made payable to **Nevada State Board of Pharmacy**. Credit Cards are charged a 5% processing fee		
Credit Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express	**Credit Card #:** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	
Expiration Date: __ __ __ __ MM/YY	**CVV** (3 digits on back of card): _____	**License Amount**: $_____
Name on Card: _____		
Billing Address: _____ _____ _____		