CONTRA COSTA HEALTH SERVICES

CONTRA COSTA
ENVIRONMENTAL HEALTH DIVISION
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Annual Drug Wholesaler Notification

SECTION 1: Type of Notification

◉ Annual Notification ○ Revised Annual Notification

SECTION 2: Drug Wholesaler Information

DRUG WHOLESALER NAME / DBA:	
DRUG WHOLESALER CONTACT PERSON:	
DRUG WHOLESALER ADDRESS:	
CITY/STATE/ZIP CODE:	
DRUG WHOLESALER CONTACT PHONE # :	DRUG WHOLESALER CONTACT FAX #:
DRUG WHOLESALER CONTACT EMAIL:	DRUG WHOLESALER WEBSITE:

SECTION 3: Covered Drug Information

* Submit the names and manufacturers of all covered drugs that the drug wholesaler sells or distributes in the unincorporated area of the county.

☐ Check box if attaching additional list for manufactures and covered drugs.

DRUG MANUFACTURES:	COVERED DRUGS:

I certify, under penalty of perjury under the laws of the State of California, that the information on this application and any accompanying documents is true and correct, with the full knowledge that all statements and accompanying documents are subject to investigation, and any false or dishonest information or accompanying documents may be grounds for denial or other actions.

Signature of Applicant: _____ Print Name: _____ Date: _____

FOR OFFICE USE ONLY

FA#:	SR#:	AR#:	P/E:	ASSIGNED TO:	RECEIVED BY:	DATE RECEIVED:

AMOUNT DUE:	AMOUNT PAID:	CHECK #:	METHOD OF PAYMENT:	RECEIPT #:
$	$		❑ CASH ❑ CHECK ❑ CREDIT CARD	XR