

**WYOMING STATE BOARD OF PHARMACY**

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**APPLICATION FOR REGISTRATION  
UNDER THE WYOMING CONTROLLED SUBSTANCES ACT  
AS A MANUFACTURER, DISTRIBUTOR, OR RETAILER OF METHAMPHETAMINE PRECURSOR DRUGS**

**REGISTRATION FEE: \$25.00**

Name of Company (DBA): \_\_\_\_\_

Name of Business (if different than above): \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

**Physical Address** (if different than mailing address) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax number: \_\_\_\_\_ Email: \_\_\_\_\_

**Renewal Address** (if different than mailing or physical address) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax number: \_\_\_\_\_ Email: \_\_\_\_\_

**Business Activity** (check only one):

- Manufacturer
- Wholesaler/Distributor
- Retail Outlet

**Type of Ownership:**     Individual     Partnership     Corporation     LLC

**Names of Owners:**

Provide names and addresses of owner(s) if individual or partnership; names of each corporate officer and director if a corporation; or names of members and addresses if a limited liability company (may attach list):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Methamphetamine Precursor Application  
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**Methamphetamine Precursor Drugs Sold:**

Please note only the following type of products are covered by W.S. 35-7-1059 (e) through (p) and are subject to the provisions of this law. ***Please check each category which is sold by your company.***

Any non-liquid product containing ephedrine or pseudoephedrine or phenylpropanolamine in any combination or in combination with any another active ingredient.

Any liquid product containing ephedrine or pseudoephedrine as the **sole active ingredient**.

I hereby apply for registration as required by W.S. § 35-7-1059 (m) to distribute methamphetamine precursor drugs as allowed under this law. I further state that I have received and reviewed W.S. 35-7-1059 (e) through (p) and understand my requirements regarding the allowed display and sale of the products covered by this law.

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Printed Name: \_\_\_\_\_

**Registrations expire annually on September 30th. The Board of Pharmacy will mail renewal notices in July.**

**If you have any questions, please contact our office.**

***Applications received not completed or signed will be returned.***

***For Board use only.***

Date received: \_\_\_\_\_ Amount paid: \_\_\_\_\_ Check number: \_\_\_\_\_

License Number: \_\_\_\_\_ Date license mailed: \_\_\_\_\_