

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES</b> Public Health Service FOOD AND DRUG ADMINISTRATION <b>REGISTRATION OF DRUG ESTABLISHMENT/                  LABELER CODE ASSIGNMENT</b> (In accordance with Public Law 92-387)	FDA USE ONLY	FDA USE ONLY
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**NOTICE:** This report is required by law (21 C.F.R. 207.20). Failure to report can result in imprisonment for not more than one year or a fine of not more than \$1,000, or both. (FD&C Act, Section 303).

**SECTION A - SITE INFORMATION**

REPORTING FIRM NAME	STATE OF INC.	REGISTRATION NUMBER
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SITE ADDRESS (No P.O. Box)	SITE TELEPHONE NUMBER ( )
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CITY	STATE	ZIP CODE	COUNTRY	BUSINESS CATEGORY: <input type="checkbox"/> HUMAN <input type="checkbox"/> VETERINARY
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SITE MAILING ADDRESS (If different from site address)

CITY	STATE	ZIP CODE	COUNTRY	SITE INTERNET/EMAIL ADDRESS
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DOING BUSINESS AS (DBA) NAME OF FIRM (if applicable)

PARENT COMPANY NAME

<b>REASON(S) FOR SUBMISSION</b> <input type="checkbox"/> Firm Registration <input type="checkbox"/> Registration of Additional Site <input type="checkbox"/> Re-Registration <input type="checkbox"/> LC Assignment <input type="checkbox"/> Name Change	<input type="checkbox"/> Address Change <input type="checkbox"/> Merger/Buyout <input type="checkbox"/> Reentry into Business with Same Name <input type="checkbox"/> Out of Business	<b>TYPE OF OWNERSHIP</b> <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Coop. Assn. <input type="checkbox"/> Corporation <input type="checkbox"/> Other _____	<b>PERSON SUBMITTING DATA AND TELEPHONE</b>  <b>BUSINESS TYPE</b> <input type="checkbox"/> Manufacturer <input type="checkbox"/> Repacker <input type="checkbox"/> Relabeler	<input type="checkbox"/> Distributor* <input type="checkbox"/> Foreign Country <input type="checkbox"/> Analytical Lab <input type="checkbox"/> Other _____
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**SECTION B - FIRM COMPLIANCE MAILING ADDRESS** for Annual Listing Report and/or Firm Correspondence

NUMBER AND STREET AND/OR P.O. BOX and ATTENTION LINE and/or Internal Mail Code	TELEPHONE NUMBER ( )
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CITY	STATE	ZIP CODE	COUNTRY	COMPLIANCE INTERNET/EMAIL ADDRESS
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**SECTION C - ADDITIONAL FIRM AND SITE INFORMATION**

NAME OF OWNER, PARTNERS OR OFFICERS	TITLE	POSITION

**OTHER FIRMS DOING BUSINESS AT THIS SITE**

LABELER CODE	FIRM NAME	LABELER CODE	FIRM NAME

**SECTION D - SIGNATURE**

SIGNATURE OF AUTHORIZING OFFICIAL	TITLE	DATE
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**\*DISTRIBUTOR'S CERTIFICATION:** As a, Distributor, I am submitting product listing information to the FDA on my own behalf. I have provided a copy of this certification (Form FDA 2656) to the registered manufacturer(s). My signature and phone number are listed below.

<b>RETURN THIS FORM TO:</b> FOOD AND DRUG ADMINISTRATION INFORMATION MANAGEMENT TEAM, HFD-095 5600 FISHERS LANE ROCKVILLE, MD 20857 INTERNET: DRUGLISTING@CDER.FDA.GOV	SIGNATURE OF DISTRIBUTOR  DISTRIBUTOR'S TELEPHONE NUMBER ( )
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If using Federal Express, DHL or any special carrier to return the forms, please use the following address:

(Please refer to the Drug Registration and Listing Instruction Booklet.)

When completing this form, please refer to the Drug Registration and Listing Instruction Booklet for assistance.  
PLEASE PRINT IN ENGLISH USING BLACK INK.

**Public reporting burden for this collection of information** is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to:

Food and Drug Administration  
Information Management Team, HFD-095  
5600 Fishers Lane  
Rockville, MD 20857

*An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.*

Please **DO NOT RETURN** this form to this address.