Virginia Department of
Health Professions
Board of Pharmacy

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APPLICATION FOR REGISTRATION AS A NON-RESIDENT MEDICAL EQUIPMENT SUPPLIER

Check Appropriate Box(es):

☐ New [1]	$235.00	☐ Change of Responsible Party	No Fee
☐ Change of Ownership	$65.00	☐ Change of Location [1]	No Fee
☐ Change of Tradename [1]	No Fee	☐ Reinstatement [2]	Call Board

Application fees are not refundable. Applications are valid for one year from the date of receipt. The required fees must accompany the application. Make check payable to "Treasurer of Virginia".

Applicant—Please provide the information requested below. (Print or Type) Use full name not initials		
Name of Firm		**FEIN Number**
Street Address	**Telephone Number**	**Fax Number**
City	**State**	**Zip Code**
Email address	**Current Virginia facility license, if applicable** **0237-**	
Name of Responsible Party	**Telephone Number**	

Responsible Party – Please read and sign the following statement:
I have read the Virginia laws and regulations relating to medical equipment suppliers. When dispensing to residents of the Commonwealth of Virginia, I will operate in accordance with the provisions of these laws and regulations.

Signature of Responsible Party	**Date**

IMPORTANT: Please carefully read and complete page 2 and 3 of this application.

1 – Provide copy of resident state license

2 - If reinstatement, complete the following:

- **Request for reinstatement is due to ☐ lapse of permit ☐ suspension or revocation of permit**
- **Has this facility operated as a medical equipment supplier during the time the permit was lapsed, suspended, or revoked? ☐ Yes ☐ No**

FOR BOARD USE ONLY:			
Date Processed:	**Check Number:**	**Receipt Number:**	**Application Number:**
Reviewed by:	**Date Reviewed:**	**Permit Number:** **0237-**	**Date Issued:**

A medical equipment supplier permit is needed to dispense prescription medical devices or oxygen for medical use to consumers. In the space below, please check the box for the items you will dispense.

- ☐ Medical Oxygen
- ☐ Hypodermic Needles and Syringes
- ☐ Sterile Water and Saline for Irrigation
- ☐ Peritoneal Dialysis Solutions
- ☐ Schedule VI controlled substances with no medicinal properties that are used for the operation and cleaning of medical equipment
- ☐ *Schedule VI controlled devices

  Please list _____

  _____

  _____

*A Schedule VI controlled device is one in which the label should bear the legend "Caution: Federal Law Restricts This Device To Sales By Or On The Order Of A _____." (The blank should be completed with the word "Physician," "Dentist," "Veterinarian," or with the professional designation of any other practitioner licensed to use or order such device.)

OWNERSHIP TYPE—check one: ☐ Corporation ☐ Partnership ☐ Individual

Name of Corporation if different from name on application: _____

Street Address: _____ **Phone No.** _____

City: _____ **State:** _____ **Zip Code:** _____

List all other trade or business names used by this facility:

Name: _____ **Name:** _____

Name: _____ **Name:** _____

LIST OF OWNERS/OFFICERS AND RESIDENCE ADDRESSES (may be provided as an attachment):

Name: _____ **Title:** _____

Residence Address: _____

Name: _____ **Title:** _____

Residence Address: _____

Name: _____ **Title:** _____

Residence Address: _____

Please respond to all of the following questions:

1. **Do the laws of your resident state require any type of licensure, registration or permit in order to operate as a supplier of durable medical equipment or oxygen? If yes, attach a photocopy of license showing the expiration date.** ☐ Yes ☐ No

2. **Does your business hold any other certification or accreditation as a provider of durable medical equipment or home care? If yes, attach documentation.** ☐ Yes ☐ No

3. **Have you or this business entity ever been convicted, pled *nolo contendere* to, or currently have charges pending for 1) any felony, 2) any misdemeanor involving moral turpitude, or 3) under any federal or state law relating to wholesale or retail distribution or delivery of prescription drugs, devices, or controlled substances? If yes, provide name of jurisdiction and date of charges or convictions, explain, and attach copies of any official documents such as warrants and court orders showing the nature and disposition of such charges or convictions.** ☐ Yes ☐ No

4. **If applicable, has any disciplinary action been taken against you or your license or permit to distribute medical equipment (prescription drugs or devices) by a licensing authority in your resident state or any other state in which you conduct business? If yes, attach a copy of the relevant documentation showing the nature and disposition of the matter.** ☐ Yes ☐ No

5. **Does your facility physically store and distribute prescription drugs or devices at the address indicated on this application? If no, please provide explanation.** ☐ Yes ☐ No

6. **Does your facility meet applicable requirements for proper storage and distribution of drugs and devices in the resident state?** ☐ Yes ☐ No

7. **Is your facility located in a private dwelling or residence?** ☐ Yes ☐ No

8. **Is your facility maintained in a clean and orderly manner?** ☐ Yes ☐ No

9. **Do you receive and maintain on file a valid order from a practitioner authorized to prescribe prior to dispensing prescription medical equipment or oxygen to a consumer?** ☐ Yes ☐ No

10. **Do you maintain records for at least two years, which include name and address of patients, item dispensed, quantity, and date of dispensing showing all dispensing of medical equipment and oxygen?** ☐ Yes ☐ No