

MINNESOTA BOARD OF PHARMACY

2829 UNIVERSITY AVE SE #530, MINNEAPOLIS, MN 55414-3251

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Relay Service: Metro Area (651) 297-5353 – Non-Metro Area 800-627-3529

E-Mail: pharmacy.board@state.mn.us - Web: www.pharmacy.mn.gov

APPLICATION FOR MEDICAL GAS DISTRIBUTOR LICENSE

LICENSE EXPIRES NOVEMBER 30 OF EACH YEAR

FEE: \$110.00

Make Check Payable to: Minnesota Board of Pharmacy

NO RETURN OR REFUND OF FEES

State of Minnesota Taxpayer Identification Number: Federal 41-6007162 - State 4405717

NEW MEDICAL GAS DISTRIBUTOR: Date of proposed opening in Minnesota --
CHANGE IN: Date of proposed change --

- Ownership Formerly: _____
- Name Formerly: _____
- Address Formerly: _____
- Location/dimension Please attach copies of the plans or a sketch of the new location.

FACILITY HOURS: M-F _____ to _____ Saturday _____ to _____ Sunday _____ to _____

PHONE NUMBER: _____ **FAX NUMBER:** _____

E-MAIL ADDRESS: _____

1. Print, type, or check all applicable boxes.

Distributor Name: _____
Street Address: _____
City, State, Zip: _____

2. Check the appropriate item and complete ownership information:

Sole Proprietor; Partnership; Limited Liability Partnership; Corporation; Limited Liability Corp

Fill in: Name of Sole Proprietor, Partnership, or Corporation: _____

Address: _____

City, State, Zip: _____

Partnership or Limited Liability Partnership: List all active and inactive partners. If a new partnership or limited liability partnership, please attach a copy of the partnership papers.

Name	Address	RPh?	% of Ownership

Corporation or Limited Liability Corporation: List all shareholders owning 20% or more of the voting stock, all officers and their titles. If a new Corporation or Limited Liability Corporation, please attach corporation papers.

Name	Address	RPh?	% of Ownership

List the state of incorporation: _____

List the number of shares of common or voting stock issued: _____

All medical gas distributors should answer the following questions:

3. **Applicant proposes to sell gases to:** Nursing Homes Home Health Agencies Public
 Hospitals Ambulance Services Wholesaler Other _____
 Medical Devices – A license is not necessary unless the drug is coated on or embedded in the device (e.g. drug-coated stents) and the resultant product is approved by the FDA as a device.

4. **Type of gases proposed for handling:** _____

5. **Please answer the following:**

- (a) On behalf of the owner, if the applicant is a sole proprietorship
- (b) On behalf of each partner, if the applicant is a partnership or a limited liability partnership
- (c) On behalf of the corporation, if the applicant is a corporation or a limited liability corporation, and on behalf of each officer, director, or shareholder owning 20% or more of the voting stock of the corporation.

- a. Has the applicant ever made application for a license to operate a pharmacy, drug manufacturing or wholesaling firm in this state or any other state? Yes No
 - (1) If yes, was the application denied by the Board of Pharmacy? Yes No
 - (2) If denied, for what reason? _____
 - (3) If the license was granted, was it later suspended, revoked, or placed on probation?
 Yes No
 - (4) Did the Board, in connection with violations, issue any warnings or reprimands?
 Yes No
 - (5) If yes, what was the nature of the violation? _____
- b. Has the applicant been convicted of theft of drugs or the unauthorized use, possession, or sale thereof?
 Yes No If yes, specify: _____
- c. Has the applicant been convicted in any court of a felony? Yes No

6. Federal Tax ID _____ If MN Resident, MN Tax ID _____

7. **ALL MEDICAL GAS DISTRIBUTORS LOCATED IN THE STATE OF MINNESOTA MUST COMPLETE THE FOLLOWING:**

1981 Laws, Chapter 346 requires that you supply us with information concerning your worker's compensation insurance, for this firm, prior to the issuance of the license. Please check the applicable box below:

- Self-insured, please attach a copy of the Certificate of Exemption from the Insurance Commissioner.
- I DO NOT employ anyone.
- I HAVE paid or otherwise compensated employees, therefore, I am furnishing the following information:

Insurance Company Name: _____
Street Address: _____
City, State, Zip Code: _____
Insurance Policy Number: _____ Date it Expires: _____

8. **ALL MEDICAL GAS DISTRIBUTORS LOCATED OUTSIDE THE BOUNDARIES OF THE STATE OF MINNESOTA:**

Please attach a copy of your current license from the state in which your facility is located and the most recent inspection report from that state or a letter explaining that your state does not require either licensure or inspections.

9. **THIS SECTION TO BE FILLED IN BY ALL FACILITIES:**

List the name, address, and phone number of a contact person at the facility:

Name _____ Phone Number: _____
Address: _____

10. **Please list address to which renewal application should be mailed, if different from the location listed in #1.**

Name: _____
Street Address: _____
City, State, Zip: _____

11. **The data you supply on this form will be used to assess your qualifications for licensure.** You are not legally required to provide this data, but we will not be able to grant the license without it. This data will constitute a public record, if and when the licensure is granted, and, at that time, copies may be issued to anyone.

I have read the above statement and I agree to supply the data on this form with full knowledge of the information provided in that statement. In addition, I, the undersigned, do hereby certify that all of the information contained in this application is true and correct and that the firm will be operated in compliance with all applicable laws and regulations.

Name of applicant – Please type or print **Signature** of Owner, Partner or Administrative Officer **Date**

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