FEES (Non-Refundable)
New Permit, Transfer of Ownership, or Re-Registration = $500.00

Fed ID # 56-6000725
Pay by Visa, MasterCard, Discover, or American Express ONLY.

No checks, money orders, or cash accepted. CREDIT CARD ONLY.

2017
APPLICATION FOR REGISTRATION AND PERMIT TO DISPENSE DEVICES AND MEDICAL EQUIPMENT

Complete and submit to: **North Carolina Board of Pharmacy**, 6015 Farrington Road, Suite 201, Chapel Hill, NC 27517. Permits expire on December 31st of the year for which it is issued.

This application is provided pursuant to North Carolina General Statute 90-85.22, which requires that all places where prescription devices and medical equipment are dispensed must obtain a permit. A business that has a current pharmacy permit does not have to register and obtain a device permit. For exemption questions, call the Board office at (919) 246-1050.

Complete electronically, then print, sign and date, and attach photo if applicable.

RESET FORM PRINT FORM

(Internal Board Use Only)
Permit #:
Batch #:
Date Issued:

http://www.ncbop.org
phone 919.246.1050
DO NOT FAX OR EMAIL APPLICATION

Under North Carolina Law, making "false representations or with[holding] material information in connection with securing a license or permit" is grounds for "refus[ing] to grant . . . a license to practice pharmacy." N.C.G.S. § 90-85.38(a)(1). Any license or permit obtained through false representation or with-holding of material information shall be void and of no effect. N.C.G.S. § 90-85.38(c).

SELECT ONE: ◯ Original Registration ◯ Transfer of Ownership* *(See item #7, next page)* ◯ Re-Registration* *(See item #7, next page)*

FOR TRANSFER OF OWNERSHIP AND RE-REGISTRATION, ENTIRE APPLICATION (INCLUDING ITEM #7) MUST BE COMPLETED.

ITEM 1: DME NAME & BUSINESS ADDRESS (REQUIRED):

DME Permit # *(Required for Transfer of Ownership or Re-Registration):* _____

DME Corporate Name *(if applicable)*: _____

DME DBA Name: _____

DME Address: _____

City: _____ State: North Carolina Zip: _____

County *(NC Only)*: _____

Facility/Business Email Address: _____

ITEM 2: PERSON IN CHARGE NAME & RESIDENTIAL ADDRESS:

Person in Charge of Permit: _____

Home Address: _____

City: _____ State: North Carolina Zip: _____

Email Address of Person In Charge: _____

SSN of Person In Charge: _____

(Enter 9-digit number only with no hyphens or spaces)

ITEM 3: TELEPHONE & FAX NUMBERS:

Phone *(Enter 10 digits only with no hyphens or spaces)*: _____

Direct Phone Number for Person in Charge *(Enter 10 digits only with no hyphens or spaces)*: _____

Fax *(Enter 10 digits only with no hyphens or spaces)*: _____

ITEM 4: CHECK ALL CATEGORIES WHICH APPLY (DO NOT LEAVE BLANK):

☐ Medical Oxygen ☐ Medical Equipment
☐ Rehabilitation Technology ☐ Respiratory Equipment

Is this DME facility located on residential property (21 NCAC 46.2601(c))? *yes or no*: _____

Will the DME facility be re-packing or manufacturing liquid or compressed oxygen USP? (Transfilling) - *yes or no*: _____

Is there a separate facility/location for storage? *yes or no*: _____

ITEM 5: LIST DAYS & HOURS OF OPERATION:

Days: _____

Hours: _____

ITEM 6: OFFICERS/OWNERS - *MUST BE COMPLETED:*

NAMES OF OFFICERS AND OTHERS. INDICATE AMOUNT, WHERE APPROPRIATE, OF STOCK OWNED IF MORE THAN 10%. NOTE APPLICABLE TITLES AND MAKE CHANGES WHERE NECESSARY.	BUSINESS ADDRESS	PERCENT OF OWNERSHIP
PRESIDENT, PRESIDING OFFICER OR EQUIVALENT		
VICE PRESIDENT OR EQUIVALENT		
SECRETARY OR EQUIVALENT		
TREASURER OR EQUIVALENT		
OTHERS		

ITEM 7: TRANSFERS OF OWNERSHIP OR RE-REGISTRATION -- *See next page.*

Continued

QUALIFICATIONS OF PERSON IN CHARGE OF DEVICES AND MEDICAL EQUIPMENT DISPENSING PERMIT

ITEM 7: TRANSFERS OF OWNERSHIP OR RE-REGISTRATION -- Fill in the following items, only at the time of transfer/re-registration ***(Re-registration required for address changes or changes in percentage of ownership between existing partners):***

Former DME Business Name: _____ Date of Transfer: _____

Former Person in Charge (if changed): _____ Name of Former Owner: _____

_____ (Signature of Former Person-in-Charge if changed)

_____ (Signature of Former Owner)

Former DME Location: _____ If Re-Registration, Eff Date of Relocation: _____

ITEM 8: CHARGES - Have you or the business ever been charged with or convicted of violation of any controlled substances laws? ***(yes or no):*** _____

If yes, explain in detail below. Attach any court orders or documents with application:

ITEM 9: Is this DME business licensed in any other state? ***(yes or no):*** _____ **If yes, how many?** _____ **List state(s):** _____

(Please use 2-letter state abbreviations and attach additional documentation if more space is needed.)

ITEM 10: Out-of-State Facility (DME facilities located outside of NC):

1) Are you licensed/permitted in the state in which the facility is located? ***(yes or no)*****:** _____

If yes, name of licensing agency ***(provide the Board a copy of your current license/permit if applicable):*** _____

2) Has the facility been inspected? ***(yes or no)*****:** _____ **If yes, last date the facility was inspected:** _____

ITEM 11: Has the applicant DME facility, the applicant person-in-charge, or any other agent or employee of the applicant DME facility been charged or disciplined by any licensing or permitting authority, federal or state? Discipline includes, <u>but is not limited to</u>, any letter of warning, reprimand, license suspension or revocation, permit suspension or revocation, or registration suspension or revocation. ***(yes or no)*****:** _____

If yes, please provide the Board with appropriate documentation, including <u>but not limited to</u> the charging document and any disposition of the charge.

ITEM 12: GPS COORDINATES -- Please enter your DME facility's GPS coordinates as degrees minutes-decimal, (e.g. 35°54.63, -78°58.998) or degree decimal format, (e.g. 35.9105, -78.9833)

Latitude (North): _____

Longitude (West): _____

Need help obtaining your DME facility's GPS coordinates?
Click here: *http://www.ncbop.org/gps.htm*

ITEM 13: <u>ADDITIONAL DOCUMENTS ARE REQUIRED. READ THE PROCEDURES SHEET THOROUGHLY</u>. ***(Pictures of the DME facility and Proof of Occupancy of the addressed facility are required, as outlined in Step 2 of the Procedures Sheet.)***

ITEM 14: SIGNATURE AND PHOTOGRAPH OF PERSON-IN-CHARGE. ***(For Transfer of Ownership or Re-Registration, photo is <u>not</u> required if person in charge has not changed):***

ATTACH PASSPORT PHOTO OF PERSON-IN-CHARGE HERE

(No Black & White or Photocopies Accepted)

Not required if person-in-charge has not changed.

_____
Date

_____
Signature of Person in Charge of Permit (Required)

(Signature and/or email address indicates acceptance of the responsibility for complying with applicable laws and regulations.)

_____ _____
Email Address of Person in Charge of Permit **Direct Phone # for Person in Charge of Permit**

INCOMPLETE APPLICATIONS WILL BE RETURNED

The Person-In-Charge (PIC) is the person responsible for the permit and is required to be physically present at the facility site the majority of the time that the facility is open. The PIC is the contact person for the permit and is responsible for making sure the facility is in compliance.

<u>A PIC CAN ONLY BE ASSIGNED TO ONE DME PERMIT.</u>

North Carolina Board of Pharmacy

Print Form

6015 Farrington Road, Suite 201
Chapel Hill, North Carolina 27517
Phone: (919) 246-1050
Fax: (919) 246-1056
www.ncbop.org

AUTHORIZATION FOR CREDIT CARD CHARGE

THE NC BOARD OF PHARMACY ONLY ACCEPTS PAYMENT VIA VISA, MASTERCARD, DISCOVER, OR AMERICAN EXPRESS.
WE DO NOT ACCEPT CHECKS.

FEE FOR NEW DME PERMIT, TRANSFER OF OWNERSHIP, OR RE-REGISTRATION IS $500.00.
YOUR CREDIT CARD WILL BE CHARGED WHEN THIS FORM IS RECEIVED IN THE BOARD OFFICE.
ALL FEES ARE NON-REFUNDABLE.

☐ VISA ☐ MasterCard ☐ DISCOVER

CREDIT CARD NUMBER *(VISA, MC, or DISCOVER)*: _____ _____ _____ _____

☐ AMERICAN EXPRESS

CREDIT CARD NUMBER *(AMERICAN EXPRESS)*: _____ _____ _____

EXPIRATION DATE *(mm / yyyy)*: _____ / _____

NAME *(exactly as it appears on the credit card)*: _____

BILLING ADDRESS: _____

ADDRESS LINE 2: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER *(will only be used in case of card processing problems)*: _____

EMAIL ADDRESS: _____

_____
SIGNATURE:

THIS FORM WILL BE DESTROYED IMMEDIATELY FOLLOWING PROCESSING OF PAYMENT.

Revised Oct 2016