# OUT-OF-STATE HOME MEDICAL DEVICE RETAILER LICENSE APPLICATION

**PLEASE COMPLETE THIS FORM FULLY—INCOMPLETE APPLICATIONS WILL BE RETURNED**

**See Page 3 for Instructions**

License Number (if not new): _____

☐ **NEW APPLICANT** ☐ **OWNERSHIP CHANGE**
☐ **RENEWAL APPLICANT** ☐ **RELOCATION**—Previous Address:

| | | | | | |
|---|---|---|---|---|---|
| 1. Name of Firm | | | 6. Mailing Address (if different or P.O. Box number) | | |
| 2. DBA (Use other sheets as needed) | | | 7. Mailing Address (continued) | | |
| 3. Facility Address (number, street) | | | 8. City | State | ZIP Code |
| 4. Facility Address (continued) | | | 9. Country (if other than United States) | | |
| 5. City | State | ZIP Code | 10. Website (URL) | | |

11. Type ownership ***Please attach evidence of ownership****

☐ Individual/Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Corporation
☐ Non Profit ☐ Other

| 12. Owner's Name/Corporate Name (if applicable) | State of Incorporation |
|---|---|
| 13. Owner's or Officers' Names and Titles | Owner's or Officers' Names and Titles |
| | |

14. Type of Application

☐ New Out of State HMDR (Never Registered) ☐ New Out of State HMDR (Additional Location) ☐ New Out of State HMDR (Relocation)
☐ New Out of State HMDR (Ownership Change) ☐ Renewal of an existing HMDR ☐ HMDR Warehouse Only (Storage)

15. Business Information. Please attach a copy of your business license and a copy of your seller's permit.

Will your business be conducting retail sales or distribution? ☐ Yes ☐ No Business License Number: _____

Business Days and Hours: _____ Seller's Permit Number: _____

16. The applicant retailer will be selling the following products (check all that apply):

☐ Respiratory Equipment/O2 Supplies[1] ☐ Incontinence Supplies ☐ Walkers, Canes, Commodes
☐ CPAPS, BiPAPS[1] ☐ Custom Wheelchairs ☐ Hospital Beds/Mattresses
☐ TENS Units[2] ☐ Power Wheelchairs[2] ☐ Air Pressure Mattresses[2]
☐ Infusion Pumps[1] ☐ Manual Wheelchairs ☐ Other—describe below or attach list of products
☐ Catheters[1] ☐ Nutritional Supplements _____
☐ CPM Machines ☐ Diabetic Test Supplies[2] _____

**PLEASE CONTINUE TO NEXT PAGE**

[1] Indicates prescription device. Must have Pharmacist-in-Charge (PIC) or a Licensed Exemptee on premises.
[2] Indicates product may be a prescription device.

# OUT-OF-STATE HOME MEDICAL DEVICE RETAILER LICENSE APPLICATION
## Continued

License Number (if not new): _____

17. If the HMDR facility will be selling/renting prescription devices, respiratory equipment, or medical oxygen:

Will there be a pharmacist in charge (PIC) at this location? ☐Yes ☐No If yes, attach copy of PIC card

Will there be an HMDR exemptee in charge of operations at this location? ☐Yes ☐No If yes, attach copy of exemptee card

Name: _____ License Number: _____

Name: _____ License Number: _____

18. Do you have a Medi-Cal or MediCare provider number? If currently applying for one, please check the box labeled "Pending". Attach a copy of certificate or proof of accreditation.

Medi-Cal Provider? ☐Yes ☐No ☐Pending Quality Standards Accrediting Agency: _____

MediCare Provider? ☐Yes ☐No ☐Pending Date of most recent accrediting audit: _____

19. Payment Code (Check all that apply)

| | | | |
|---|---|---|---|
| ☐ A | $ 242.00 | Base Fee | Fee is due at the time application is submitted and is NON-REFUNDABLE |
| ☐ B | $ 10.00 | Late Fee | If over 30 days past license expiration date |
| | $ _____ | TOTAL AMOUNT DUE | Payable to: CA Department of Public Health |

**Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says: (1) he/she is the applicant, or one of the owners or managers of the applicant corporation, named in the foregoing application, duly authorized to make this application on its behalf; (2) that he/she has read the foregoing application and knows the contents thereof and that each and all statements therin are made true; (3) that no person other than the applicant or applicants has nay direct or indirect interest in the applicant's or applicants' business to be conducted under the license(s) for which this application is made; (4) all supplemental statements are true and accurate.**

| 20. Owner's Signature | Owner's Printed Name | Title Owner/ | Date |
|---|---|---|---|
| | | | |

## Authorized Representatives and/or Signatories:

| 21. Business Operator Name | 22. Telephone Number | 23. Emergency Number | 24. E-Mail Address |
|---|---|---|---|
| | | | |
| 25. Correspondent Name | 26. Telephone Number | 27. Alt Phone Number | 28. E-Mail Address |
| | | | |

**End of Application. Please note: All boxes must be completed.**

| License Number | Expiration Date | Date Received | Payment Type | Amount $ |
|---|---|---|---|---|
| | | | | |

# Out-of-State Home Medical Device Retailer Registration
## Application Instructions

A separate application is required for each place of business. Please complete and/or amend this application as is most appropriate to your facility. Include the appropriate fee for each application as indicated in the fee schedule and payable to: CA DEPARTMENT OF PUBLIC HEALTH. This fee must accompany this application. Without the fee the application cannot be processed. Unsigned or incomplete applications cannot be processed. The following are further instructions on how to complete this application: **Do not leave any sections blank.**

**New Applicant / Renewal Applicant:** Place an (X) in the box next to New Applicant if your firm has not previously applied for an Out-of-State Home Medical Device Retailer Registration at this location while under the current ownership. Place an (X) in the box next to Renewal Applicant if your firm has already obtained an Out-of-State Home Medical Device Retailer Registration for this location, and you are renewing that registration. If your firm has changed location, ownership, or both, place an (X) in the box adjacent to the appropriate response. **Check one box only.**

1. **Legal Name of Firm:** Enter full name of business, corporation, company, or organization applying for registration.
2. **DBA:** Enter any other name(s) your company is doing business as.

3.–5. **Facility Address:** Enter the number, street, city, state, and zip code for this facility location.

6.–8. **Mailing Address:** Enter the full mailing address if different from the facility address or enter P.O Box.

9. **Country:** Enter full name of country where facility is located, if outside the United States
10. **Website URL:** Enter the website address of your business, if applicable
11. **Type of Ownership:** Place an (X) in the box next to the appropriate legal description of the facility's ownership. (Attach copy)
12. **Owner's Name of Corporate Name:** Enter corporate name if applicable. Enter state of incorporation if applicable.
13. **Owners' or Officers' Names:** List the business owners' or officers' names and titles. Attach a list if needed.
14. **Type of Application:** Place an (X) in the box next to the type of application you are submitting.
15. **Business Information:** Place an (X) in the box adjacent to the type of business being conducted at this location and enter the business days and hours. Enter the Business license and Seller's Permit and attach required copies.
16. **Types of Products:** Place an (X) in the box adjacent to the type of products your business will be selling. Check all that apply.
17. **Name of Pharmacist-in-charge (PIC) or Equivalent Name and License Number:** ATTACH A COPY OF THE PIC CARD TO YOUR APPLICATION
18. **Medi-Cal or MediCare Provider:** Place an (X) in the boxes adjacent to your answer to each question on provider types.

**PLEASE CONTINUE TO NEXT PAGE**

## Out-of-State Home Medical Device Retailer Registration
## Application Instructions Continued

19. **Payment Code:** Your registration fee is based on the type of activity at your facility.

| *Registration Category* | *Fee* | *Interval of Renewal and Fees* |
|---|---|---|
| Out-of-State retail firm new applicant, renewal, relocation, or additional location | $242 | First Registration or Annual Fee |
| Late Fee – All Categories | $10 | Due if over 30 days past license registration date |

**REGISTRATION FEES ARE NON-REFUNDABLE AND NON-TRANSFERABLE TO OTHER LOCATIONS OR ENTITIES**

20. **Owner's Signature:** Owner of the facility must sign here. Printer name, title, and date signed.

21-24: **Business Operator Information:** Print the business operator's name, telephone number, 24-Hour emergency contact phone number, and e-mail address.

25-28: **Correspondent Information:** Printer the business correspondent's name, telephone number, alternative phone number, and e-mail address.

MAKE CHECKS PAYABLE TO: **DEPARTMENT OF PUBLIC HEALTH**

MAIL APPLICATION AND CHECK TO ONE OF THE ADDRESSES BELOW

| | | | |
|---|---|---|---|
| **Regular Mail:** | California Department of Public Health<br>Food and Drug Branch – Cashier<br>MS 7602<br>P.O. Box 997435<br>Sacramento, CA 95899-7435 | **Overnight Mail:** | California Department of Public Health<br>Food and Drug Branch – Cashier<br>1500 Capitol Ave MS 7602<br>Sacramento, CA 95814 |

**If you have any questions about this application, please contact the Home Medical Device Retailer desk at (916) 650-6500, (800) 495-3232.**

**The Food and Drug Branch must approve this application before an Out-of-State Home Medical Device Retailer registration is issued. If changes are made during the application process, you may need to submit a new application with appropriate fees. Fees applied to this application are not transferable and are not refundable.**

Any material misrepresentation in response to any question is grounds for refusal or subsequent revocation of registration, and a violation of the California Penal Code. All items of information in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.