HOME MEDICAL DEVICE RETAILER EXEMPTEE LICENSE APPLICATION – NEW AND RENEWAL

Read instructions on attached sheet. Unsigned or incomplete applications will not be processed.

License Number: _____

☐ **New Exemptee** ☐ **Relocation** ☐ **Ownership Change** ☐ **Additional License** ☐ **Renewal**

1. Legal Name of Applicant: Last	First	Middle	Former
Residence address: Number and Street	City	State	Zip Code
Home phone number:	Date of birth:	If Renewal, Exemptee license No:	

2. Name of HMDR facility where Exemptee will be working and / Business days and hours when Exemptee will be dispensing or distributing prescription devices. (If currently employed by a HMDR facility.)		
Address of HMDR facility: Number and Street	City	State / Zip Code
Work phone number:	HMDR license number of employer (leave blank if unknown):	Expiration date:

3. Contact Name (if different from exemptee name):			
4. Mailing Address (if different from HMDR facility):	City	State	Zip Code

5. **(The following questions are for NEW APPLICANTS ONLY)**
Please provide the following information to determine if you meet the minimum qualifications.

Do you have a high school diploma or equivalent? ***(Attach a copy)*** ☐ Yes ☐ No

Do you hold any of the following professional certifications or licenses: ***(Attach a copy)***
☐ Respiratory Therapist ☐ LVN ☐ RN ☐ PT ☐ OT ☐ Pharmacy Technician ☐ Other_____

Have you had one year or more paid experience related to the distribution or dispensing of dangerous drugs or dangerous devices? ***(Provide proof of 1 year experience)*** ☐ Yes ☐ No

Have you completed training program(s) that address the following: (Attach copy of completed training certificate)

State and Federal laws relating to the distribution of dangerous drugs and dangerous devices?	☐ Yes	☐ No
State and Federal laws relating to the distribution of controlled substances?	☐ Yes	☐ No
Knowledge and understanding of quality control systems?	☐ Yes	☐ No
The United States Pharmacopoeia standards relating to the safe storage and handling of drugs?	☐ Yes	☐ No
The safe storage and handling of home medical devices?	☐ Yes	☐ No
Prescription terminology, abbreviations, and format?	☐ Yes	☐ No

For all of the above questions answered yes, you must submit appropriate proof to verify qualifications.

6. **Certification of Exemptee - Please read carefully and sign below**

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license. I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in this application, including all supplementary statements. I also certify that I personally completed this application and have read and understand the instructions attached to this application.

Applicant Exemptee signature: (in full, no initials)	Date:

THIS IS TO BE COMPLETED BY EMPLOYER (If Applicant is currently employed by a HMDR facility.)

7. Legal Name of Home Medical Device Retailer:	HMDR license number:
Business name: (if different)	
Facility Address: Number and Street City State Zip Code	

8. The applicant medical device retailer will sell the following products: (Check all that apply)

- ☐ Respiratory Equipment / O2 Supplies
- ☐ CPAPS, BiPAPS
- ☐ TENS Units
- ☐ Infusion Pumps
- ☐ Catheters
- ☐ CPM Machines
- ☐ Incontinence Supplies
- ☐ Custom Wheelchairs
- ☐ Power Wheelchairs
- ☐ Manual Wheelchairs
- ☐ Nutritional Supplements
- ☐ Diabetic Test Supplies
- ☐ Walkers, Canes, Commodes
- ☐ Hospital Beds / Mattresses
- ☐ Other: Describe Below or attach list of products.

_____

9. . Does this Home Medical Device Retailer currently employ the person whose name appears on this application? ☐ Yes ☐ No

10. Will this person replace an Exemptee licensed by the California Department of Public Health? ☐ Yes ☐ No (Attach Proof)

Name of Exemptee being replaced: _____ Exemptee Number: _____

11. List business hours and days that the applicant will be working at this facility: _____

_____

12. Enter other Exemptee license number(s) that applicant possesses:

_____

13. If applicant is working at various locations explain how the facility intends to provide coverage in applicant's absence:

(attach a separate sheet if necessary)

Certification of Employer – Read carefully and sign below

I hereby certify that the application completed on this form is being presented to the Food and Drug Branch with my knowledge and approval. Also, it is my understanding that a person certified by the Food and Drug Branch must be on the premises and actively supervising operations at all times when prescription devices are being dispensed. I certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers, and representations made in the foregoing application, including all supplementary statements.

14. Employer's original signature: (*in blue ink*)	Title of person signing:	Date:

15. **License Fee Due (Fee is Non Refundable)** **Enter Fee Below:**

License fee due (see page 4)	**$**

Make Checks Payable to: **CALIFORNIA DEPARTMENT OF PUBLIC HEALTH**
See page 4 for mailing address

Home Medical Device Retailer Exemptee License Application Instructions

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 make check payable to: CA DEPARTMENT OF PUBLIC HEALTH. The application cannot be processed without the appropriate fees, complete documentation and appropriate signatures. Unsigned or incomplete applications cannot be processed and will be returned. The following are further instructions on how to complete this application:

1. ***Your Information***: Your legal name as it is to appear on the license issued by the Department of Public Health. *Residence address*: Enter the number, street, city, state and Zip code for your residence. If this is a renewal, enter your current Exemptee license number.
2. ***Employer Information***: The legal name of the Home Medical Device Retailer facility where you will be distributing prescription devices. *(If currently employed by a HMDR facility.) Address:* Enter the number, street, city, state and Zip code for this facility.
3. ***Correspondent***: Enter the name of the person to contact for information regarding this application and their title.
4. ***Mailing Address***: This address is where licensing information is to be sent if the address is a different location than the Employer address.
5. ***Minimum qualifications***:
   - ***Education:*** **High school diploma GED or equivalent. Attach copies of any applicable certifications or licenses that you may hold.**
   - ***Work Experience*: One or more years paid experience, attach dates, name(s) of employer(s), and addresses. Training must have been supervised by a licensed exemptee, Pharmacist-In-Charge or equivalent.**
   - ***Training Programs:*** **Indicate by yes or no the training you have completed specific to the five topics listed. Attach copies of certificates or transcripts.**
6. ***Certification of Applicant:*** After reading the instruction paragraph your signature is needed, please sign in full (no initials) and date.

Numbers 7 through 15 are to be completed by the employer. (If currently employed by a HMDR facility.)

7. ***Name of Firm***: Enter the full name of the business, *HMDR license*: Enter the current Home Medical Device Retailer facility license number. *Corporate Name:* Name of corporation if different from HMDR name. *Facility Address*: Enter the number, street, city, state and Zip code for this facility location.
8. ***Products type:*** Place an (x) in the boxes that correctly describe products that this firm handles (check all that apply).
9. ***Current Employment:*** Check the appropriate box to verify employment.
10. ***Replacement of Licensed Exemptee:*** *Check box:* if applicant is replacing a licensed Exemptee. *Name:* Exemptee being replaced.
    Certificate number: Exemptee being replaced certificate number. (Attach copy)
11. ***Enter business days and hours of application at facility.***
12. ***Enter any other Home Medical Device Retailer Exemptee license numbers applicant possesses.***
13. ***Provide explanation of Home Medical Device Retailer facility coverage in controlling prescription products when applicant is unavailable.***

Home Medical Device Retailer Exemptee License Application Instructions Continued

14. **Certification of Employer:** After reading the instruction paragraph the employer's original signature is needed, please sign, state title of signatory and date the signature.

15. ***Payment***

License Category	*Fee*	*Interval*
Exemptee Application Fee / License fee	**$403**	**New (Never licensed as Exemptee with FDB)**
Exemptee License Fee	**$242**	**Annual Renewal**
Exemptee License Fee	**$242**	**Additional license, Relocation, Change of Ownership**
Late Fee	**$10**	**Due if 30 Days past license expiration**

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

MAKE CHECKS PAYABLE TO: California Department of Public Health

MAIL APPLICATION AND CHECK TO:

Regular Mail:
California Department of Public Health
Food and Drug Branch – Cashier
MS 7602
P.O. Box 997435
Sacramento, CA 95899-7435

Overnight Mail:
California Department of Public Health
Food and Drug Branch — Cashier
1500 Capitol Ave MS 7602
Sacramento, CA 95814

If you have any questions, please contact the Home Medical Device Retailer Exemptee Licensing Desk at (916) 650-6500, (800) 495-3232.