



**OKLAHOMA STATE BOARD OF PHARMACY**

4545 Lincoln Blvd., Suite 112, Oklahoma City, OK 73105-3413

Phone: (405) 521-3815 / Fax: (405) 521-3758

www.pharmacy.ok.gov / e-mail: pharmacy@pharmacy.ok.gov

**FEE: \$400**  
(includes inspection and/or document review)

**MEDICAL GAS DISTRIBUTOR PERMIT APPLICATION**

<b>✓ Check all that apply</b>	NEW
	CHANGE OF OWNERSHIP
	CHANGE OF LOCATION
	CHANGE OF NAME

<b>FOR OSBP USE ONLY:</b>		
LICENSE	ISSUED	REPLACES
RECEIPT	DATE	

<b>Describe your business practice at this location:</b>	<b>(✓Check all that apply)</b>	I supply medical gas on drug orders issued to a patient.
	<b>(✓Check all that apply)</b>	I distribute medical gas to medical gas suppliers or other entities licensed to use, administer, or distribute medical gas.
	<b>(✓Check all that apply)</b>	Other. Please describe:

1. List NAME and/or DBA and **street address** of facility: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
2. Mailing Address (if different than #1): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
3. If the facility listed in #1 above is **NOT LOCATED IN OKLAHOMA** – please attach a copy of this facility's license as issued by the resident state where it is located.
4. Facility manager: \_\_\_\_\_ E-Mail: \_\_\_\_\_
5. Phone: \_\_\_\_\_ Toll Free: \_\_\_\_\_ Fax: \_\_\_\_\_
6. Facility hours: Mon - Fri \_\_\_\_\_ Saturday \_\_\_\_\_ Sunday \_\_\_\_\_
7. Type of ownership: ( \_\_\_ Individual) ( \_\_\_ Partnership) ( \_\_\_ Corporation)    8. State of incorporation: \_\_\_\_\_
9. Name of Partnership or Corporate owner of facility listed in #1: \_\_\_\_\_
10. List Individual Owner, Partners, or Corporate Officers for facility listed in #1 (*attach separate page if necessary*):  
 Name/title \_\_\_\_\_  
 Name/title \_\_\_\_\_
11. Has the manager, the owner or the business been arrested, charged or convicted, or received a deferred sentence for any misdemeanor or felony offense or been disciplined for violation of laws or regulations relating to prescription drugs?  
**Yes \_\_\_ No \_\_\_ ➡ If YES, please complete addendum and attach.**
12. Person responsible for application: \_\_\_\_\_ E-Mail: \_\_\_\_\_

I swear and affirm under penalty of perjury pursuant to Title 21 O.S. 491 and/or discipline by the Board of Pharmacy under the pharmacy laws and rules of the State of Oklahoma, that all information I have supplied herein is true and complete to the best of my knowledge and belief.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PERMIT EXPIRES ANNUALLY – 12 MONTHS FROM ISSUE**  
**PLEASE ALLOW 2-3 WEEKS FOR PROCESSING AND, IF APPLICABLE, PHYSICAL INSPECTION**  
**(Note: physical inspection will occur for all in-state facilities)**

