



\$FEE – \$200

OKLAHOMA STATE BOARD OF PHARMACY

4545 Lincoln Blvd., Suite 112, Oklahoma City, OK 73105-3488
Phone: (405) 521-3815 / Fax: (405) 521-3758
www.pharmacy.ok.gov / e-mail: pharmacy@pharmacy.ok.gov

**Fee doubles 15 days
after expiration**
EXPIRES: _____
Receipt No. _____
Receipt Date _____

**2008-2009 NOTICE OF RENEWAL
MEDICAL GAS DISTRIBUTOR PERMIT**

1. **Name and/or dba and street address of facility:** 2. **Mailing address:**

Permit No. _____

Please PRINT clearly – list name
and/or dba and address

3. Check if applicable: **Name Change** **Ownership Change** **Address Change**

ALL blanks must be completed. If not applicable, enter N/A. Please allow 2-3 weeks for processing and mailing of your permit. Verification of receipt will not be done over the telephone. You may request verification that your renewal was received by enclosing a self-addressed, stamped envelope.

4. **Describe your business practice at this location:**
(√check all that apply)
- I distribute medical gas to medical gas suppliers or other entities licensed to use, administer, or distribute medical gases
- I distribute medical gas on drug orders issued to a patient.
- Other. Please describe: _____

5. Facility manager: _____ E-Mail: _____

6. Phone: () _____ Toll Free: () _____ Fax: () _____

7. Facility hours: Mon - Fri _____ Saturday _____ Sunday _____

8. Type of ownership: (___ Individual) (___ Partnership) (___ Corporation) 9. State of incorporation: _____

10. Name of Partnership or Corporate owner of facility listed in #1: _____

11. List Individual Owner, Partners, or Corporate Officers for facility listed in #1 (attach separate page if necessary):

Name/title _____ Name/title _____
Name/title _____ Name/title _____

12. Within the last 15 months or since the last renewal, 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, state details on a separate page and attach.

13. Is the facility listed above in #1 located in Oklahoma? Yes No
➡ If NO, please attach a copy of this facility's license as issued by the resident state where it is located.

14. Name and title of person responsible for application: _____

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 _____