



**\$FEE – \$200**

**OKLAHOMA STATE BOARD OF PHARMACY**

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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 \_\_\_\_\_

**2009-2010 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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.**

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 \_\_\_\_\_