



**FEE- \$100**

**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](http://www.pharmacy.ok.gov) / e-mail: [pharmacy@pharmacy.ok.gov](mailto:pharmacy@pharmacy.ok.gov)

FOR OSBP USE ONLY	
RECEIPT:	
DATE:	

**2012-2013 NOTICE OF RENEWAL  
MEDICAL GAS SUPPLIER PERMIT**

**Fee doubles 15 days after expiration  
EXPIRES: \_\_\_\_\_**

[If you have had a Name change, Ownership change, or Address change you must complete a new application. New applications are available at [www.pharmacy.ok.gov](http://www.pharmacy.ok.gov).]

1. **NAME and/or DBA & STREET ADDRESS of facility:**

2. **Mailing address (if different from #1):**

Permit No. \_\_\_\_\_

Please PRINT clearly

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please allow a minimum of 21 days from date of receipt for processing and mailing of your permit.

3. **Describe your business practice at this location:**     I supply medical gas only on drug orders issued to a patient.  
 Other. Please describe: \_\_\_\_\_

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. 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 \_\_\_\_\_

9. Within the last 24 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, complete addendum and attach.

10. 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.

11. 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 \_\_\_\_\_