



OKLAHOMA STATE BOARD OF PHARMACY

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**\$200
- FEE -**

IN-STATE MEDICAL GAS SUPPLIER PERMIT APPLICATION

- 1. List name and/or dba and street address of facility: _____

- 2. Mailing address: _____

3. Check one: _____ **NEW** _____ **CHANGE** (Ownership / Name / Location)

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:** I supply medical gas only on drug orders issued to a patient.
(check all that apply) 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. 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 _____