HOME MEDICAL DEVICE RETAILER LICENSE APPLICATION
PLEASE COMPLETE THIS FORM FULLY—INCOMPLETE APPLICATIONS WILL BE RETURNED
See Page 3 for Instructions

License Number (if not new): _____

☐ **NEW APPLICANT** ☐ **OWNERSHIP CHANGE**
☐ **RENEWAL APPLICANT** ☐ **RELOCATION**—Previous Address:

1. Name of Firm			6. Mailing Address (if different or P.O. Box number)		
2. DBA (Use other sheets as needed)			7. Mailing Address (continued)		
3. Facility Address (number, street)			8. City	State	ZIP Code
4. Facility Address (continued)			9. Country (if other than United States)		
5. City	State	ZIP Code	10. Website (URL)		

11. Type ownership ***Please attach evidence of ownership****

☐ Individual/Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Corporation
☐ Non Profit ☐ Other

12. Owner's Name/Corporate Name (if applicable)	State of Incorporation
13. Owner's or Officers' Names and Titles	Owner's or Officers' Names and Titles

14. Type of Application

☐ New HMDR (Never Licensed) ☐ New HMDR (Additional Location) ☐ New HMDR (Relocation)
☐ New HMDR (Ownership Change) ☐ Renewal of Existing HMDR ☐ HMDR Warehouse Only (Storage)

15. Type of Business to be conducted at this location:

☐ Retail Sales/ Distribution ☐ Warehouse Only Business Days and Hours: _____

16. The applicant retailer will be selling the following products (check all that apply).

☐ Respiratory Equipment/O2 Supplies[1]
☐ CPAPS, BiPAPS[1]
☐ TENS Units[2]
☐ Infusion Pumps[1]
☐ Catheters[1]
☐ CPM Machines
☐ Incontinence Supplies
☐ Custom Wheelchairs
☐ Power Wheelchairs[2]
☐ Manual Wheelchairs
☐ Nutritional Supplements
☐ Diabetic Test Supplies[2]
☐ Walkers, Canes, Commodes
☐ Hospital Beds/Mattresses
☐ Air Pressure Mattresses[2]
☐ Other—describe below or attach list of products

_____
_____

PLEASE CONTINUE TO NEXT PAGE

[1] Indicates prescription device. Must have Pharmacist-in-Charge (PIC) or a Licensed Exemptee on premises.
[2] Indicates product may be a prescription device.

HOME MEDICAL DEVICE RETAILER LICENSE APPLICATION
Continued

License Number (if not new): _____

17. If the HMDR facility will be selling/renting prescription devices, respiratory equipment, or medical oxygen:

Will there be a pharmacist in charge (PIC) at this location? ☐ Yes ☐ No If yes, attach copy of PIC card

Will there be an HMDR exemptee in charge of operations at this location? ☐ Yes ☐ No If yes, attach copy of exemptee card

Name: _____ License Number: _____

Name: License Number:

18. Do you have a Medi-Cal or MediCare provider number? If currently applying for one, please check the box labeled "Pending". Attach a copy of certificate or proof of accreditation.

Medi-Cal Provider? ☐ Yes ☐ No ☐ Pending Quality Standards Accrediting Agency: _____

MediCare Provider? ☐ Yes ☐ No ☐ Pending Date of most recent accrediting audit:

19. Payment Code (Check all that apply)

☐ A	$1,369.00	Base Fee	Fee is due at the time application is submitted and is NON-REFUNDABLE
☐ B	$ 686.00	Warehouse Fee	If applicable. Fee is due at the time application is submitted and is NON-REFUNDABLE
☐ C	$ 10.00	Late Fee	If over 30 days past license expiration date
	$	TOTAL AMOUNT DUE	Payable to: CA Department of Public Health

Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says: (1) he/she is the applicant, or one of the owners or managers of the applicant corporation, named in the foregoing application, duly authorized to make this application on its behalf; (2) that he/she has read the foregoing application and knows the contents thereof and that each and all statements therin are made true; (3) that no person other than the applicant or applicants has nay direct or indirect interest in the applicant's or applicants' business to be conducted under the license(s) for which this application is made; (4) all supplemental statements are true and accurate.

20. Owner's Signature	Owner's Printed Name	Title Owner/	Date

Authorized Representatives and/or Signatories:

21. Business Operator Name	22. Telephone Number	23. Emergency Number	24. E-Mail Address
25. Correspondent Name	26. Telephone Number	27. Alt Phone Number	28. E-Mail Address

End of Application. Please note: All boxes must be completed.

License Number	Expiration Date	Date Received	Payment Type	Amount $

Home Medical Device Retailer Registration
Application Instructions

A separate application is required for each place of business. Please complete and/or amend this application as is most appropriate to your facility. Include the appropriate fee for each application as indicated in the fee schedule and payable to: CA DEPARTMENT OF PUBLIC HEALTH. This fee must accompany this application. Without the fee the application cannot be processed. Unsigned or incomplete applications cannot be processed. The following are further instructions on how to complete this application: **Do not leave any sections blank.**

New Applicant / Renewal Applicant: Place an (X) in the box next to New Applicant if your firm has not previously applied for a Home Medical Device Retailer Registration at this location while under the current ownership. Place an (X) in the box next to Renewal Applicant if your firm has already obtained a Home Medical Device Retailer Registration for this location, and you are renewing that registration. If your firm has changed location, ownership, or both, place an (X) in the box adjacent to the appropriate response. **Check one box only.**

1. **Legal Name of Firm:** Enter full name of business, corporation, company, or organization applying for registration.
2. **DBA:** Enter any other name(s) your company is doing business as.

3.–5. **Facility Address:** Enter the number, street, city, state, and zip code for this facility location.

6.–8. **Mailing Address:** Enter the full mailing address if different from the facility address or enter P.O Box.

9. **Country:** Enter full name of country where facility is located, if outside the United States
10. **Website URL:** Enter the website address of your business, if applicable
11. **Type of Ownership:** Place an (X) in the box next to the appropriate legal description of the facility's ownership. (Attach copy)
12. **Owner's Name of Corporate Name:** Enter corporate name if applicable. Enter state of incorporation if applicable.
13. **Owners' or Officers' Names:** List the business owners' or officers' names and titles. Attach a list if needed.
14. **Type of Application:** Place an (X) in the box next to the type of application you are submitting.
15. **Type of Business:** Place an (X) in the box adjacent to the type of business being conducted at this location and list business days and hours.
16. **Types of Products:** Place an (X) in the box adjacent to the type of products your business will be selling. Check all that apply.
17. **Selling or Renting Prescription Devices, Medical Oxygen, or Respiratory Equipment:** Place an (X) in the boxes next to your answer for both questions. If you answered yes to either question, print the name of the licensee, print their license number, and attach a copy of their PIC or Exemptee card.
18. **Medi-Cal or MediCare Provider:** Place an (X) in the boxes adjacent to your answer to each question on provider types. Attach proof of accreditation, accrediting agency, and last audit date.

PLEASE CONTINUE TO NEXT PAGE

Home Medical Device Retailer Registration
Application Instructions Continued

19. **Payment Code:** Your registration fee is based on the type of activity at your facility. Place an (X) next to the correct payment code(s) and add the total. That is the total amount due at the time of submission.

Registration Category	*Fee*	*Interval of Renewal and Fees*	*Payment Code*
Base Fee	$1,369	First license or Relocation, Ownership Change, Relocation, Ownership Change, or Annual Fee	A
Warehouse	$686	First license or Relocation, Ownership Change, Relocation, Ownership Change, or Annual Fee	B
Late Fee – All Categories	$10	Due if over 30 days past license registration date	C

REGISTRATION FEES ARE NON-REFUNDABLE AND NON-TRANSFERABLE TO OTHER LOCATIONS OR ENTITIES

20. **Owner's Signature:** Owner of the facility must sign here. Printer name, title, and date signed.

21-24. **Business Operator Information:** Print the business operator's name, telephone number, 24-Hour emergency contact phone number, and e-mail address.

25-28. **Correspondent Information:** Printer the business correspondent's name, telephone number, alternative phone number, and e-mail address.

MAKE CHECKS PAYABLE TO: **CA DEPARTMENT OF PUBLIC HEALTH**
MAIL APPLICATION AND CHECK TO ONE OF THE ADDRESSES BELOW

Regular Mail:	California Department of Public Health Food and Drug Branch – Cashier MS 7602 P.O. Box 997435 Sacramento, CA 95899-7435	**Overnight Mail:**	California Department of Public Health Food and Drug Branch – Cashier 1500 Capitol Ave MS 7602 Sacramento, CA 95814

If you have any questions about this application, please contact the Home Medical Device Retailer desk at (916) 650-6500, (800) 495-3232.

The Food and Drug Branch must approve this application before an Out-of-State Home Medical Device Retailer registration is issued. If changes are made during the application process, you may need to submit a new application with appropriate fees. Fees applied to this application are not transferable and are not refundable.

Any material misrepresentation in response to any question is grounds for refusal or subsequent revocation of registration, and a violation of the California Penal Code. All items of information in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.