HOME MEDICAL DEVICE RETAILER LICENSE APPLICATION

PLEASE COMPLETE THIS FORM FULLY—INCOMPLETE APPLICATIONS WILL BE RETURNED

See page 2 for instructions

☐NEW APPLICANT ☐RELOCATION ☐ OWNERSHIP CHANGE ☐ OWNERSHIP AND LOCATION CHANGE ☐RENEWAL

1. Legal Name of Firm			9. Facility Operator (name and title)		
2. DBA (List additional DBA's on separate sheet if necessary.)			10. Facility Telephone Number ( )	11. Facility FAX Number ( )	
3. Facility Address (number, street)			12. 24-Hour Emergency Telephone Number ( )	13. E-mail Address	
4. Facility Address (continued)			14. Correspondent (name and title)		
5. City	State	ZIP Code	15. Correspondent Telephone Number ( )	16. Correspondent FAX Number ( )	
6. Mailing Address (if different or P.O. Box number)			17. County		
7. Mailing Address (continued)			18. Website (URL)		
8. City	State	ZIP Code			

19. Type of Ownership

☐ Individual/Sole Proprietorship ☐ Partnership ☐ Corporation/Limited Liability Company ☐ Other:_____

20. Corporate Name (if applicable)	State of Incorporation
21. Owners' or Officers' Names and Titles	Owners' or Officers' Names and Title s (Attach a separate list if needed).

22. Type of Application

☐ New HMDR (never licensed) ☐ New HMDR (additional location)

☐ New HMDR (ownership change) _____ (previous HMDR license number) ☐ New HMDR relocation _____ (previous HMDR license number)

☐ Renewal of an existing HMDR _____ (HMDR license number) ☐ HMDR Warehouse Only (storage) _____ (retail facility HMDR license number)

23. Type of Business to be Conducted at this Location: ☐ Retail Sales/Distribution ☐ Warehouse Only

☐ Business days and hours:_____

24. The applicant retailer will be selling the following products: (check all that apply) *** Asterisk indicates prescription device - must have Pharmacist-in-charge (PIC) or a Licensed Exemptee on premises. ** Asterisks indicate product may be a prescription device.**

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

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

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

b. Will there be an HMDR exemptee in charge of operations at this location? ☐ Yes ☐ No (If Yes, attach a copy of exemptee license)

Name:_____ Exemptee License Number: _____

Name:_____ Exemptee License Number:_____

26. Do you have a Medi-Cal or MediCare Provider number? (If currently applying for one, please check the Pending box)

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

Medicare Provider? ☐ Yes ☐ No Pending ☐ Date of most recent accrediting audit:_____ (attach copy of certificate/proof of accreditation)

27. Payment Codes (Check only one code—see page 2 for schedule.)

☐ A—$1,304 ☐ B—$1,304 ☐ C—$653

(Fees are Non-Refundable)

MAKE CHECKS PAYABLE TO:
CA DEPARTMENT OF PUBLIC HEALTH
See page 2 for mailing address.

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 therein made are true; (3) that no person other than the applicant or applicants has any 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.

28. Signature of Applicant (original signature)	Printed name	Title	Date

License Number	Expiration Date	Date Received	Payment Type	Amount

PLEASE DO NOT WRITE IN GRAY AREA ABOVE THIS LINE. – FOR STATE USE ONLY

California Department of Public Health

Home Medical Device Retailer License 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 License 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 License for this location, and you are renewing that license. 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 licensure.
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.

9. **Facility Operator:** Enter the full name of the person who manages the operations at this facility and their title.
10. **Facility Telephone Number:** Enter daytime business telephone number of this facility.
11. **Facility FAX Number:** Enter facility FAX number.
12. **24-Hour Emergency Telephone Number:** Enter telephone number to be called in the event of an emergency.
13. **E-mail Address:** Enter facility e-mail address.
14. **Correspondent:** Enter the name of the person to contact for information regarding this application and their title.
15. **Correspondent Telephone Number:** Enter the daytime business telephone number of the contact person.
16. **Correspondent FAX Number:** Enter the daytime business FAX number of the contact person.
17. **County:** Enter the county where your facility is located.
18. **Website:** Enter the website address for your business, if applicable
19. **Type of Ownership:** Place an (X) in the box next to the appropriate legal description of the facility's ownership.
20. **Corporate Name:** Enter corporate name if applicable. Enter state of incorporation if applicable.
21. **Owners' or Officers' Names:** List the business owners' or officers' names and titles. Attach a list if needed.
22. **Type of Application:** Place an (X) in the box next to the type of application you are submitting.
23. **Type of Business Conducted:** Place an (X) in the box adjacent to the type of business being conducted at this location and list business days and hours.
24. **Type of Products Selling:** Place an (X) in the box adjacent to the type of products your business will be selling. Check all that apply.
25. **Selling or Renting Prescription Devices, Medical Oxygen, or Respiratory Equipment:** Place an (X) in the boxes next to your answer for question a. and b. If you answered yes, provide the name of the exemptee and their license number.
26. **Medi-Cal or Medicare Provider:** Place an (X) in the boxes adjacent to your answer to each question on provider types. For Medicare providers only, place the name of the quality standards accrediting agency, date of most recent audit, and accreditation certificate/proof of accreditation.
27. **Payment Codes:** Your license fee is based on the type of activity at your facility. Based on the chart below, place an (X) in the correct payment code box on the first page (mark only one box A–C).

License Category	*Fee*	*Interval of Renewal and Fees*	*Payment Code*
New Instate Firm	$1,304.00	First license or Relocation, Ownership Change, Relocation and Ownership Change	A
Renewal	$1,304.00	Annually on renewal	B
Warehouse only	$653.00	First license or Relocation, Ownership Change, Relocation and Ownership Change and Annual renewal	C

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

28. **Provide original signature** and print your name, print your title, and enter the date.

MAKE CHECKS PAYABLE TO: **CA DEPARTMENT OF PUBLIC HEALTH**

MAIL APPLICATION AND CHECK TO:

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 Avenue, MS-7602
Sacramento, CA 95814

If you have any questions about this application, please contact the Home Medical Device Retailer Licensing Desk at (916) 341-7354, (800) 495-3232 or send an email to FDBMedDevice@cdph.ca.gov. You may also visit our internet website for timely program news and a blank copy of this application form.

The Food and Drug Branch must approve this application before a Home Medical Device Retailer license 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 license, 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.