OUT-OF-STATE HOME MEDICAL DEVICE RETAILER REGISTRATION 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. Country (if other then United States)	
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:_____

(attach copy of Partnership Agreement or Articles of Incorporation)

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

22. Type of Application

☐ New Out of State HMDR (never registered) ☐ New HMDR (additional location)

☐ New Out of State HMDR (ownership change) _____ (previous HMDR registration number)

☐ New Out of State HMDR (address change) _____ (previous HMDR registration number)

☐ Renewal of an existing HMDR _____ (HMDR registration number)

☐ HMDR Warehouse Only (storage) _____ (retail facility HMDR registration number)

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

☐ Business License Number:_____ (attach copy of business license)

☐ Business days and hours:_____

☐ Seller's Permit Number:_____ (attach copy of Seller's Permit)

24. The applicant retailer will be selling the following products: (check all that apply) ***Asterisk indicates prescription device – must have a Pharmacist-in-Charge or valid Exemptee. ** Asterisk indicates product may be a prescription device.**

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

25. Pharmacist-in-charge (PIC) or Equivalent Name:_____ License Number: _____ **(Attach copy of license.)**

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 ☐
MediCare Provider? ☐ Yes ☐ No Pending ☐

27. Payment

☐—**$230 (Fee is Non-Refundable)**

MAKE CHECKS PAYABLE TO:
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 registration(s) for which this application is made; (4) all supplemental statements are true and accurate.

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

PLEASE DO NOT WRITE BELOW THIS LINE.

Registration Number	Expiration Date	Date Received	Payment Type	Amount
				$

Out-of-State 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 an Out-of-State 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 an Out-of-State 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. **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. **Country**: Enter the country where your facility is located, if outside of United States.
18. **Website:** Enter the website 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. (Attach copy)
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 enter the business days and hours. Enter the Business license and Seller's Permit and attach required copies.
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. **Name of Pharmacist-in-charge (PIC) or Equivalent Name and License Number:** ATTACH A COPY OF THE PIC CARD TO YOUR APPLICATION.
26. **Medi-Cal or Medicare Provider:** Place an (X) in the boxes adjacent to your answer to each question on provider types.
27. **Payment Codes:** Your registration fee is based on the type of activity at your facility.

Registration Category	***Fee***	***Interval of Renewal and Fees***
Out-of-State retail firm	$230	First Registration
Out-of-State retail firm renewal, relocation, add location	$230	Annual

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

28. Sign the application, print your name, print your title, and enter the date.

MAKE CHECKS PAYABLE TO: **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 desk at (916) 341-7354, (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.