HOME MEDICAL DEVICE RETAILER EXEMPTEE LICENSE APPLICATION

All fields must be completed. Incomplete applications will result in delayed license issuance.

See page 3 for instructions.

☐ **New Exemptee** ☐ **Renewal** ☐ **License Number (if not new):** _____

1. Legal Name of Applicant: (Last, First, Middle)	
Residence Address: (Number, Street)	
Residence Address: (City, State, ZIP Code)	
Direct Phone Number:	Date of Birth:

2. HMDR Facility Information: (For additional facilities, please use separate page) Facility Address: (Number, Street, City, State, ZIP Code)			
HMDR License Number:	HMDR License Expiration Date:		
3. Contact Name for Facility:			
4. Mailing Address (if different from HMDR facility):	City	State	Zip Code

NEW APPLICANTS ONLY

5. Please provide the following information to determine if you meet the minimum qualifications. If you have the requirements for 5A, please skip 5B.

a) Do you hold any of the following professional certifications or licenses: ***(Attach a copy)***

☐ Respiratory Therapist ☐ LVN ☐ RN ☐ PT ☐ OT

☐ Pharmacy Technician ☐ Other:

b) Do you have a high school diploma or equivalent? ☐ Yes ☐ No

Have you had one year or more paid experience related to the distribution or dispensing of dangerous drugs or dangerous devices? ***(Provide proof of 1 year experience)*** ☐ Yes ☐ No

Have you completed training program(s) that address the following:
(Attach copy of completed training certificate)

State and Federal laws relating to the distribution of dangerous drugs and dangerous devices? ☐ Yes ☐ No

State and Federal laws relating to the distribution of controlled substances? ☐ Yes ☐ No

Knowledge and understanding of quality control systems? ☐ Yes ☐ No

The United States Pharmacopoeia standards relating to the safe storage and handling of drugs? ☐ Yes ☐ No

The safe storage and handling of home medical devices? ☐ Yes ☐ No

Prescription terminology, abbreviations, and format? ☐ Yes ☐ No

For all the above questions answered **yes**, please submit appropriate proof to verify qualifications.

- Continue -

6. License Fee: (check all that apply)
Fee is due at the time application is submitted and is NON-REFUNDABLE.

A ☐	New Applicant License Fee $444.00	$_____	**Make check payable to: CA Department of Public Health** Please see page 3 for Mailing address
B ☐	Annual Renewal License Fee $267.00	$_____	
C ☐	Late Fee (if over 30 days past license expiration date) $10.00	$_____	
	TOTAL AMOUNT DUE	$_____	

7. **Certification of Exemptee - Please read carefully and sign below**
I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license. I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in this application, including all supplementary statements. I also certify that I personally completed this application and have read and understand the instructions attached to this application.

Exemptee's Signature	Exemptee's Printed Name	Date

- End of Application -
Please review your application to ensure all fields have been completed.

Do not write below this line. CDPH FDB Use Only.

License Number	Expiration Date	Date Received	Payment Type	Amount $

Home Medical Device Retailer Exemptee License Application Instructions

(Do not send instructions with completed application)

Starting July 1, 2025, HMDR Exemptees are only required to maintain a single Exemptee license per individual. If you work at multiple HMDR facilities, this single license will appy to all those facilities. Only submit one HMDR Exemptee License application per person, as application fees are non-refundable. Include the appropriate fee for each application as indicated in the fee schedule. The application cannot be processed without the appropriate fees, complete documentation, and appropriate signatures. Unsigned or incomplete applications cannot be processed and will be returned.

1. **Your Information:** Your legal name as it is to appear on the license issued by the Department of Public Health. *Residence address*: Enter the number, street, city, state, and Zip code for your residence. Enter the best phone number to reach you at.
2. **HDMR Facility Information:** The legal name of the Home Medical Device Retailer facility where you will be distributing prescription devices. *(If currently employed by a HMDR facility) Address:* Enter the number, street, city, state, and Zip code for this facility.
3. **Correspondent:** Enter the name of the person to contact for information regarding this application and their title.
4. **Mailing Address:** This address is where licensing information is to be sent if the address is a different location than the Employer address.
5. **Minimum qualifications:**
   a.) Professional certifications or licenses: Please check all that apply. Attach copies of any applicable certifications or licenses that you may hold. If you have any of these certifications or licenses, you may skip 5b.
   b.) Education: High school diploma GED or equivalent. *Work Experience*: One or more years paid experience, attach dates, name(s) of employer(s), and addresses. Training must have been supervised by a licensed exemptee, Pharmacist-In-Charge, or equivalent. *Training Programs:* Indicate by yes or no the training you have completed specific to the five topics listed. Attach copies of certificates or transcripts.
6. **License Fee:**

A	$444.00	New Applicant License Fee	New applicants who have never been licensed as an Exemptee with FDB
B	$267.00	Annual Renewal License Fee	Annual license renewal
C	$10.00	Late Fee	If over 30 days past license expiration date

License Fees are Non-Refundable and Non-Transferable to Other Locations or Entities.

7. **Certification of Applicant:** After reading the instruction paragraph your signature is needed, please sign in full (no initials) and date.

Please make all checks payable to: **CA Department of Public Health** Mail Application and checks 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

Contact the Food and Drug Branch at FDBMedDevice@cdph.ca.gov if you have additional questions about this application.