



## 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. **Country:** Enter the country where your facility is located, if outside of United States.
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. (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 list business days and hours. Enter Business license, FEIN, and Seller's Permit number 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. **Selling or Renting Legend 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.
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).

<i>License Category</i>	<i>Fee</i>	<i>Interval of Renewal and Fees</i>	<i>Payment Code</i>
New Instate Firm	\$850.00	First license or Relocation	A
Renewal	\$850.00	Annually on renewal	B
Warehouse only	\$425.00	First license 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 License Voice Mailbox at (916) 650-6500 and leave a message with your firm name, your name, and your phone number and a staff member will return your call. You may also visit our internet web site at: <http://www.cdph.ca.gov/programs/Pages/FDB.aspx> 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.