Virginia Department of Health Professions
Board of Pharmacy

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
(804) 367-4456 (Tel)
(804) 527-4472 (Fax)
pharmbd@dhp.virginia.gov
www.dhp.virginia.gov/pharmacy

APPLICATION FOR A MEDICAL EQUIPMENT SUPPLIER PERMIT

Check Appropriate Box(es):

☐ New[1]	$235.00	☐ Change of Responsible Party[2]	No Fee
☐ Change of Ownership	$65.00	☐ Change of Location[1]	$300.00
☐ Change of Tradename	No Fee	☐ Remodeling[1]	$300.00
☐ Reinstatement[1]			

If reinstatement, due to: ☐ **Lapse of Permit** **or** ☐ **Suspension or Revocation of a Permit**

Application fees are not refundable. Applications are valid for one year from the date of receipt. The required fees must accompany the application. Make check payable to "Treasurer of Virginia".

Please provide the information requested below. Send ORIGINAL application to the Board for processing.

Name of Firm		**Area Code and Telephone Number**	
Street Address		**Area Code and Fax Number**	
City		**State**	**Zip Code**
If a current Medical Equipment Supplier permit is held, indicate the permit number **0206-**	**Federal Employment Identification Number (FEIN)**	**Telephone Number (currently working number)**	
(Print) Name of the Responsible Party (if change of Responsible party, list incoming)			
SIGNATURE OF RESPONSIBLE PARTY **If change of Responsible Party, signature of incoming Responsible Party. By affixing my signature I acknowledge that I work at the address on this application and will act as the Responsible Party at this location.**		**[2] Effective Date of Change (if change of Responsible Party, date assuming role as Responsible Party)**	
		Date	**Email Address of Responsible Party**
Expected Hours of Operation		**Expected Opening, Moving, or Completion Date**	**Requested Inspection Date [1]**

[1] A 14-day notice is required for scheduling an opening or change of location inspection. Products for which the permit is required may not be stocked prior to inspection and approval. An inspector will call prior to the requested date to confirm readiness for inspection. If the inspector does not call to confirm the date, the responsible party should call the Enforcement Division at 804-367-4691 to verify the inspection date with the inspector.

FOR OFFICE USE ONLY:

Date processed:	**Check No:**	**Receipt No:**		**Application No:**
Assigned Inspection Date:	**Date Inspected:**	**Reviewed By:**	**Date Reviewed:**	**Date Issued:**
Permit Number **0206-**	**Date Scanned to Enforcement:**			

A Medical Equipment Supplier permit is required to dispense the products listed below to consumers. Provide in the space below, or as an attachment, a brief description of your planned business activities for which you need this registration including examples of the products you intend to dispense.

A Schedule VI controlled device is one in which the label should bear the legend "Caution: Federal Law Restricts This Device To Sales By Or On The Order Of A _____ ." (The blank should be completed with the word "Physician," "Dentist," "Veterinarian," or with the professional designation of any other practitioner licensed to use or order such device.) [3]

Check all that apply:

- ☐ **Medical Oxygen**
- ☐ **Hypodermic Needles and Syringes**
- ☐ **Sterile Water and Saline for Irrigation**
- ☐ **Peritoneal Dialysis Solutions**
- ☐ **Schedule VI controlled substances with no medicinal properties that are used for the operation and cleaning of medical equipment**
- ☐ **Schedule VI controlled devices [3]**

  Please list

  _____

  _____

  _____

OWNERSHIP TYPE—check one: Corporation ☐ Partnership ☐ Individual ☐

Name of Corporation if different from name on application: _____

Street Address: _____ Phone No. _____

City: _____ State: _____ Zip Code: _____

List all other trade or business names used by this facility:

Name: _____ **Name:** _____

Name: _____ **Name:** _____

LIST OF OWNERS/OFFICERS AND RESIDENCE ADDRESSES (may be provided as an attachment):

Name: _____ Title: _____

Residence Address: _____

Name: _____ Title: _____

Residence Address: _____