Virginia Department of Health Professions
Board of Pharmacy

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APPLICATION FOR A PERMIT AS A MEDICAL EQUIPMENT SUPPLIER

Check Appropriate Box(es):

☐ New[1]	$180.00	☐ Change of Responsible Party	No Fee
☐ Change of Ownership	$50.00	☐ Change of Location[1]	$150.00
☐ Change of Tradename	No Fee	☐ Reinstatement[2]	
☐ Remodel	$150.00		

The required fees must accompany the application.
Make check payable to "Treasurer of Virginia".

Applicant—Please provide the information requested below. (Print or Type) Use full name not initials		
Name of Firm	Federal Employment Identification Number (FEIN)	
Street Address	Facility Telephone Number	
City	State	Zip Code
Email address	Current Virginia facility license, if applicable 0206-	
Name of Responsible Party	Telephone Number for Responsible Party	
Expected Opening Date	Requested Inspection Date[1]	
Signature of Applicant	Date	

IMPORTANT: Please carefully read and complete page 2 of this application.

[1] A 14-day notice is required for scheduling an opening or change of location inspection.

[2] If reinstatement, complete the following:

- Request for reinstatement is due to ☐ lapse of permit ☐ suspension or revocation of permit
- Has this facility operated as a medical equipment supplier during the time the permit was lapsed, suspended, or revoked? ☐ Yes ☐ No

FOR BOARD USE ONLY:			
Date Processed:	Check No:	Receipt No:	Application No:
Date Issued:	Permit Number:	Reviewed by:	Date Reviewed:

A medical equipment supplier permit is needed to dispense prescription medical devices or oxygen for medical use to consumers. Please include, 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 prescription items you plan to dispense:

- ☐ **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

_____

_____

_____

[3] 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.)

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: _____