Minnesota Board of Pharmacy
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APPLICATION FOR MEDICAL GAS DISPENSER REGISTRATION

Registration expires November 30 of each year

New Application Fee: $400.00
Relocation Fee: $400.00
Remodel: No Fee

Make Check Payable to: Minnesota Board of Pharmacy

NO RETURN OR REFUND OF FEES

State of Minnesota Taxpayer Identification Number: Federal 41-6007162 - State 4405717

New Medical Gas Dispenser, date of proposed opening in Minnesota: _____
Current Medical Gas Dispenser, date of proposed change: _____
Current Minnesota Registration Number, if applicable: _____

☐ New Applicant: **Instate only**- attach a copy of the blueprint indicating the location of the medical gas.
☐ Relocation: **Instate only**- attach a copy of the blueprint indicating the location of the medical gas.
☐ Remodel: **Instate only**-attach copies of the plans or a sketch of the proposed changes/remodel.

Facility Hours: M-F _____ to _____ Saturday _____ to _____ Sunday _____ to _____
Phone Number: _____Email: _____

1. **Facility Information (Current)**
   Dispenser Name: _____
   Street Address: _____
   City, State, Zip: _____

   Current Minnesota Registeration Number, if applicable: _____

   Relocations ONLY - Provide new address information
   New Street Address: _____
   City, State, Zip: _____ Phone Number _____

2. **Ownership of the facility, check the appropriate type and complete ownership information:**

   ☐Sole Proprietor ☐Partnership ☐Limited Liability Partnership ☐Corporation ☐Limited Liability Com.
   Fill in the information of the owner: Name of Sole Proprietor, Partnership, or Corporation:
   _____
   Address:_____
   City, State, Zip: _____

If Partnership or Limited Liability Partnership: List all active and inactive partners. Attach a partnership papers and organization chart.

Name	Address	RPh?	% of Ownership

If Corporation or Limited Liability Company: List voting stock shareholders and their percentage owned. Attach a list of officers and their titles. Attach corporation papers and organization chart. Attach additional information as needed.

Name	Address	RPh?	% of Ownership

List the state of incorporation: _____
List the number of shares of common or voting stock issued: _____

All medical gas dispensers should answer the following questions:

3. **Applicant proposes to sell gases to:** ☐ Nursing Homes ☐ Home Health Agencies ☐ Public ☐ Hospitals ☐ Ambulance Services ☐ Wholesaler ☐ Other _____

4. **Type of gases proposed for handling:** _____
_____

5. **Answer the following:**

(a) On behalf of the owner, if the applicant is a sole proprietorship
(b) On behalf of each partner, if the applicant is a partnership or a limited liability partnership
(c) On behalf of the corporation, if the applicant is a corporation or a limited liability company, and on behalf of each officer, director, or shareholder owning 20% or more of the voting stock of the corporation.

a. Has the applicant ever made application for a license to operate a pharmacy, drug manufacturing or wholesaling firm in this state or any other state? ☐ Yes ☐ No
   (1) If yes, was the application denied by the Board of Pharmacy? ☐ Yes ☐ No
   (2) If denied, for what reason? _____
   (3) If the license was granted, was it later suspended, revoked, or placed on probation? ☐ Yes ☐ No
   (4) Did the Board, in connection with violations, issue any warnings or reprimands? ☐ Yes ☐ No
   (5) If yes, what was the nature of the violation? _____
b. Has the applicant been convicted of theft of drugs or the unauthorized use, possession, or sale thereof? ☐ Yes ☐ No If yes, specify: _____
c. Has the applicant been convicted in any court of a felony? ☐ Yes ☐ No

6. Federal Tax ID _____ If MN Resident, MN Tax ID _____

7. **Medical Gas Dispensers that are located in Minnesota must complete the following information:**
1981 Laws, Chapter 346 requires that you supply us with information concerning your worker's compensation insurance, for this firm, prior to the issuance of the registration. Please check the applicable box below:

☐ Self-insured, please attach a copy of the Certificate of Exemption from the Insurance Commissioner.
☐ I DO NOT employ anyone.
☐ I HAVE paid or otherwise compensated employees, therefore, I am furnishing the following information:

Insurance Company Name: _____
Street Address: _____
City, State, Zip Code: _____
Insurance Policy Number: _____ Expiration Date: _____

8. **For all non-resident (out-of-state) applicants:**
Please attach a copy of your current registration from the state in which your facility is located and the most recent inspection report from that state or a letter explaining that your state does not require either licensure or inspections.

9. **This section must be completed by all applicants:**

List the name, address, and phone number of the contact person at the facility:
Name _____ Phone Number: _____
Address: _____

10. **List the address to which renewal applications should be mailed, if different from the location listed in #1.**
Name: _____
Street Address: _____
City, State, Zip: _____

11. **The data you supply on this form will be used to assess your qualifications for registration.** You are not legally required to provide this data, but we will not be able to grant the registration without it. This data will constitute a public record, if and when the registration is granted, and, at that time, copies may be issued to anyone.

I have read the above statement and I agree to supply the data on this form with full knowledge of the information provided in that statement. In addition, I, the undersigned, do hereby certify that all of the information contained in this application is true and correct and that the firm will be operated in compliance with all applicable laws and regulations.

Name of applicant (type or print)	**Signature** of Owner, Partner or Administrative Officer	**Date**