APPLICATION FOR HOME MEDICAL DEVICE RETAILER EXEMPTEE LICENSE – NEW AND RENEWAL

License Number:	Date Received:	CID #	Amount: $

PLEASE DO NOT WRITE ABOVE THIS LINE
Read instructions on attached sheet. Unsigned or incomplete applications will not be processed.

☐ **New Exemptee** ☐ **Change of Ownership** ☐ **Relocation** ☐ **Additional License** ☐ **Renewal**

1. Legal Name of Applicant: Last First Middle Former

Residence address: Number and Street City State Zip Code

Home phone number: ( )	Date of birth:	If Renewal, Exemptee license No:	

2. Name of HMDR facility where Exemptee will be working and / Business days and hours when Exemptee will be dispensing or distributing

Address of HMDR facility: Number and Street City State Zip Code

Work phone number: ( )	HMDR license number of employer (leave blank if unknown):	Expiration date:

3. Contact Name (if different from exemptee name):

4. Mailing Address (if different from HMDR facility):	City	State	Zip Code

5. Has the applicant ever been convicted of a felony? ☐Yes ☐No **If "yes," provide an explanation on a separate sheet.**

6. **(The following questions are for NEW APPLICANTS ONLY)**
Please provide the following information to determine if you meet the minimum qualifications.

Do you have a high school diploma or equivalent? ***(Attach a copy)*** ☐Yes ☐No

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

☐ Respiratory Therapist ☐ LVN ☐ RN ☐ PT ☐ OT ☐ Pharmacy Technician ☐ Other _____

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

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 of the above questions answered yes, you must submit appropriate proof to verify qualifications.

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.

Applicant Exemptee signature: (in full, no initials)	Date:

THIS AREA IS TO BE COMPLETED BY THE EMPLOYER

8. Legal Name of Home Medical Device Retailer:	HMDR license number:
Business name: (if different)	
Facility Address: Number and Street City State Zip Code	

9. The applicant medical device retailer will sell the following products: (***Check all that apply***)

- ☐ Respiratory Equipment / O2 Supplies
- ☐ CPAPS, BiPAPS
- ☐ TENS Units
- ☐ Infusion Pumps
- ☐ Catheters
- ☐ CPM Machines
- ☐ Incontinence Supplies
- ☐ Custom Wheelchairs
- ☐ Power Wheelchairs
- ☐ Manual Wheelchairs
- ☐ Nutritional Supplements
- ☐ Diabetic Test Supplies
- ☐ Walkers, Canes, Commodes
- ☐ Hospital Beds / Mattresses
- ☐ Other: Describe Below or attach list of products.

_____

_____

10. Does this Home Medical Device Retailer currently employ the person whose name appears on this application? ☐Yes ☐No

11. Will this person replace an Exemptee approved by the California Department of Public Health? ☐Yes ☐No (Attach copy)

Name of Exemptee being replaced : _____

Exemptee Number: _____

12. List business hours and days that the applicant will be working at this facility:

_____

13. Enter other Exemptee license number(s) that applicant possesses:

_____

14. If applicant is working at various locations explain how facility intends to provide coverage in applicant's absence:

_____

(attach a separate sheet if necessary)

15. Certification of Employer – Read carefully and sign below

I hereby certify that the application completed on this form is being presented to the Food and Drug Branch with my knowledge and approval. Also, it is my understanding that a person certified by the Food and Drug Branch must be on the premises and actively supervising operations at all times when prescription devices are being dispensed. I 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 the foregoing application, including all supplementary statements.

Employer's original signature: (*in blue ink)*	Title of person signing:	Date:

Home Medical Device Retailer Exemptee License Application Instructions

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 make check payable to: CA DEPARTMENT OF PUBLIC HEALTH. 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. **Please allow 4 to 6 weeks for application processing**. The following are further instructions on how to complete this application:

1. ***Your Information*:** Your legal name as it is to appear on the license issued by the Department of Public Health. *Residence address*: is the street address of where you actually live. *City:* is the municipality where the address is located. *State:* is normally California but change to another state if you are located outside the California border. *Zip:* is the five-digit zip code. If this is a renewal, enter your current Exemptee license number.
2. ***Employer Information**:* The legal name of the Home Medical Device Retailer facility where you will be working. *Address:* is the street address of the firm where business will take place. *City:* is the municipality where the address is located. *State*: is normally California but change to another state if the firm is located outside the California border. *Zip:* is the five-digit zip code with 4-digit zip-plus for the location to be licensed.
3. ***Contact Name***: Fill in the name of the person who will keep track of the Home Medical Device License and associated records and be responsible for applying for and renewal of this license.
4. ***Mailing Address***: This address is where licensing information is to be sent if the address is a different location than the address of the location where business will take place.
5. ***Felony***: Has the applicant ever been convicted of a felony? If "Yes," provide an explanation on a separate sheet.
6. ***Minimum qualifications**: **Education:* **High school diploma GED or equivalent**. **Attach copies of any applicable certifications or licenses that you may hold. *Work Experience*: One or more years paid experience, attach dates, name(s) of employer(s), and addresses. Training must have been supervised by a license 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. Acceptable programs: CAMPS (916) 443-2115, Robert Thornburg (562)-431-7508, or Skills Plus (415)-487-3500.**
7. ***Certification of Applicant:*** After reading the instruction paragraph your signature is needed, please sign in full (no initials) and date.

Numbers 8 through 12 are to be completed by the employer.

8. ***Firm Information*:** The name of the Home Medical Device Retailer to appear on the license issued by the Department of Public Health. *HMDR license*: state current HMDR license number. *Corporate name:* Name of corporation if different from HMDR name. *Address*: is the street address of the firm where business will take place. *City:* is the municipality where the address is located. *State:* is normally California but change to another state if your firm is located outside the California border. *Zip:* is the five-digit zip code with 4-digit zip-plus for the location to be licensed.
9. ***Type of products to be sold at this firm:*** Check all appropriate boxes indicating types of products sold by this firm.
10. ***Current Employment:*** Check the appropriate box to verify employment.
11. ***Replacement of approved Exemptee:*** *Check box:* if applicant is replacing an approved Exemptee. *Name:* Exemptee being replaced. *Certificate number:* Exemptee being replaced certificate number. (Attach copy)
12. ***Enter business days and hours of application at facility.***
13. ***Enter any other exemptee license numbers applicant possesses.***
14. ***Provide explanation of coverage when applicant is unavailable.***
15. ***Certification of Employer:*** After reading the instruction paragraph the employer's original signature is needed, please sign, state title of signatory and date the signature.

Mail the completed and signed application with the licensing fee (see table below) made payable to:

California Department of Public Health
Food and Drug Branch - Cashier
P.O. Box 997435
MS-7602
Sacramento, CA 95899-7435

License Category	*Fee*	*Interval*	
Exemptee Application Fee/License fee	**$250.00**	**New (Never licensed as Exemptee with FDB)**	
Exemptee License Fee	**$150.00**	**Annual Renewal**	
Exemptee License Fee	**$150.00**	**Additional license, Relocation, Change of Ownership**	

** **LICENSE FEES ARE NON-REFUNDABLE AND NON-TRANSFERABLE TO OTHER LOCATIONS OR ENTITIES**

If you have any questions, please contact the Home Medical Device Retailer licensing desk at (916) 650-6500. You may also visit our internet web site at: http://www.cdph.ca.gov/pubsforms/Pages/FoodandDrug.aspx for timely program news and a blank copy of this application form.