

APPLICATION TO BE THE MDEG ADMINISTRATOR

Person who runs the facility on a daily basis

✂ Date

Each MDEG shall employ an administrator at all times. The administrator must be:

1. A natural person.
2. Have a high school diploma or its equivalent.
3. Have: a) At least 1500 hours of verifiable work experience relating to the products provided be the medical products provider or medical products wholesaler or b) An associate's degree or higher degree from an accredited college or university in a field of study that is directly related to patient health care.
4. Be employed be the medical products provider or medical products wholesaler at the place of business or facility of the employer at least 40 hours per week or during all regular business hours if the business or facility is regularly open less than 40 hours per week and
5. Be approved by the board.
6. The administrator shall ensure that that the operation of the business or facility complies with all applicable federal, state and local laws, regulations and rules.

A medical products provider or medical products wholesaler shall notify the staff of the Board of the cessation of employment of an administrator within 3 business days after the cessation of the employment. A medical products provider or medical products wholesaler shall notify the staff of the Board of the employment of a new administrator within 3 business dates after the beginning of the employment.

A medical products provider or medical products wholesaler may not operate for more than 10 business days without an administrator. The Board may summarily suspend the operation of a business or facility that operates without an administrator.

GENERAL INSTRUCTIONS

Type or print an answer to every question. If a question does not apply to you, so state with N/A. If space available is insufficient, use a separate sheet and precede each answer with the appropriate title. Do not misstate or omit any material fact(s) as each statement made hererin is subject to verification. Applicant must initial each page, as provided in lower right hand corner.

All applicants are advised that this application to be a MDEG administrator is an official document and misrepresentation or failure to reveal information requested may be deemed to be sufficient cause for the refusal or revocation of a license.

All applicants are further advised that an application for a license, finding of suitability or for other action may not be withdrawn without the permission of the licensing agency.

Application for

Nature of MDEG

.....
Name and Address of Business for Which MDEG Administrator Is Requested

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If applicable, Name Under Which It Is Now Operated

1. PERSONAL INFORMATION:

Last Name
 First Name
 Middle Name

Alias(es, Nicknames, Maiden Name, Other Name Changes, Legal or Otherwise)

Present Residence Address-Street or RFD	City	State/Zip
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Dates		City		State/Zip	
Present Business Address					

Dates	
Present Position with the MDEG	

Phone: _____ Fax: _____

Email address: _____

 Date of Birth _____ Place of Birth (City, County, State) _____

Age	Social Security Number	Sex
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<u>Color of Eyes</u>	<u>Color of Hair</u>	<u>Weight</u>	<u>Height</u>
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Scars, tattoos or distinguishing marks and/or characteristics _____

Are you a citizen of the United States? Yes ☐ No ☐

If alien, registration No _____

If naturalized, certificate No _____ Date _____

Place _____ (If naturalized, document must be verified.)

EMPLOYMENT:

A MDEG administrator must document that he or she has been employed for at least 1500 hours of verifiable work experience relating to the products provided by the medical products provider or medical products wholesaler. Please provide the following information to document your hours of employment.

Month and Year	Name/ Address of Employer/Business	No of Employed Hours
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Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
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Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
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Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
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Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
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Title	Description of Duties	Name of Supervisor
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Month and Year	Name/ Address of Employer/Business	No of Employed Hours
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Title	Description of Duties	Name of Supervisor
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I have ☐ I have not ☐ been diagnosed or treated in the last five years for a mental illness or a physical condition that would impair my ability to perform any of the essential functions of my license, including alcohol or substance abuse,

1. I have ☐ I have not ☐ been charged, arrested or convicted of a felony or misdemeanor.
2. I have ☐ I have not ☐ been the subject of an administrative action whether completed or pending.
3. I have ☐ I have not ☐ had a license suspended, revoked, surrendered or otherwise disciplined, including any action against a professional license that was not made public.

If you checked ~~%have+~~to questions 1, 2 and/or 3, please include the following information **and** provide a written explanation and/or documents.

a) Board Administrative Action: State: _____
b) Date: _____

Case Number: _____

c) Criminal Action: State: _____

Date: _____

Case Number: _____

County: _____

Court: _____

4 . Will you be actively involved in and aware of the daily operation of the MDEG? Yes ☐ No ☐

5 .Will you be employed fulltime with the MDEG? Yes ☐ No ☐

6 .Will you be present at the site of the MDEG during its normal operating hours? Yes ☐ No ☐

If you answer No to questions 4, 5 or 6 please provide a written letter of explanation.

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ATTACH PHOTOGRAPH
TAKEN WITHIN LAST
30 DAYS HERE

Date of photograph.....

I,....., being duly sworn, depose and say I have read the foregoing application and know the contents thereof; that the statements contained herein are true and correct and contain a full and true account of the information requested; that I executed this statement with the knowledge that misrepresentation or failure to reveal information requested may be deemed sufficient case for denial or revocation of a MDEG license; that I am voluntarily submitting this application with full knowledge that Nevada Revised Statutes 639.210 (10) provides denial or revocation of the application of any person for a certificate, license, registration or permit if the holder or applicant ~~has~~ obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false or fraudulent, and further, that I have familiarized myself with the contents of Nevada Revised Statutes and Regulations.

I hereby expressly waive, release and forever discharge the State of Nevada, the licensing agency and its agents from any and all manner of action and causes of action whatsoever which I, my administrators or executors can, shall or may have against the State of Nevada, the licensing agency and its agents, as a result of my applying to be a designated representative for a pharmacy or MDEG in the State of Nevada.

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Original Signature of Applicant