NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Parkway, Suite 206 – Reno, NV 89521 – 775-850-1440

Medical Products Provider and Wholesaler – Medical Devices, Equipment and Gases (MDEG) Administrator Application

Rev (06/21/2022)

NAC 639.694

1. **Each medical products provider or medical products wholesaler shall employ an administrator at all times. The administrator must:**
   a. Be a natural person;
   b. Have a high school diploma or its equivalent;
   c. Have:
      i. At least 1,500 hours of verifiable work experience relating to the products provided by the medical products provider or medical products wholesaler; or
      ii. 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;
   d. Be employed by 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
   e. Be approved by the Board.
2. The administrator shall ensure that the operation of the business or facility complies with all applicable federal, state and local laws, regulations and rules.
3. 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 days after the beginning of the employment.
4. 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.

NAC 639.6946

1. Except as otherwise provided in NAC 639.6945, a medical products provider shall:
   a. Provide services for all medical products sold, leased or otherwise provided by the medical products provider, including, without limitation, set up, repair and maintenance.
   b. Employ an administrator and other employees sufficient to provide the services described in paragraph (a).

NAC 639.6957

1. A medical products wholesaler shall:
   a. Employ a facility administrator and other employees sufficient to operate, set up, repair, maintain and service all medical products sold, leased or otherwise provided by the medical products wholesaler.

Please mail this completed application and all other required documents with your MDEG and/or Wholesaler Application to the address indicated above.

If you have any questions, please contact the Nevada State Board of Pharmacy at 775-850-1440 or by email at pharmacy@pharmacy.nv.gov.

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Section 1: Pharmacy/ MDEG/Wholesaler Information

Name of MDEG ______________________________ MDEG License # (if applicable) ______________

Physical Address ______________________________

City ______________________________ State ____________ Zip ______________________

Mailing Address (if different from physical address) ______________________________

City ______________________________ State ____________ Zip ______________________

Telephone ______________________ Website ______________________________

Licensing Company Email ______________________________

Section 2: Personal Information

First ______________________ Middle ______________________ Last ______________________

Alias(es, nicknames, name changes, etc.) ______________________________

Date of Birth ______________________ SSN or ITIN ______________________ Sex ☐ M ☐ F ☐ X

Mailing Address ______________________________

City ______________________________ State _______ Zip ______________

Telephone ______________________ Email ______________________________

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

Section 3: Military Service (NRS 622.120)	Yes	No
1. Have you ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable? (Mark "Yes" if discharged honorably.)		
2. Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States and separated from such service under conditions other than dishonorable? (Mark "Yes" if discharged honorably.)		
3. Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States and separated from such service under conditions other than dishonorable? (Mark "Yes" if discharged honorably.)		

Section 4: Federally Mandated Requirement (NRS 425.520, NRS 639.129)	Yes	No
1. Are you the subject of a court order for the support of a child? (If "yes", answer question 2.)		
2. Are you in compliance with the order or the plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order?		

Section 5: List your high school and college experience beginning with the most current. (Use a separate piece of paper if additional space is needed.)			
School Name		From - To (MM/YY – MM/YY)	
Address	City	State	Zip
Diploma/Degree obtained, if any			
School Name		From - To (MM/YY – MM/YY)	
Address	City	State	Zip
Diploma/Degree obtained, if any			
School Name		From - To (MM/YY – MM/YY)	
Address	City	State	Zip
Diploma/Degree obtained, if any			
School Name		From - To (MM/YY – MM/YY)	
Address	City	State	Zip
Diploma/Degree obtained, if any			
School Name		From - To (MM/YY – MM/YY	
Address	City	State	Zip
Diploma/Degree obtained, if any			

Section 6: List all residences you have had for the last 10 years beginning with the most current. (Use a separate piece of paper if additional space is needed.)				
From - To (MM/YY – MM/YY)	Address	City	State	Zip
From - To (MM/YY – MM/YY)	Address	City	State	Zip
From - To (MM/YY – MM/YY)	Address	City	State	Zip
From - To (MM/YY – MM/YY)	Address	City	State	Zip
From - To (MM/YY – MM/YY)	Address	City	State	Zip
From - To (MM/YY – MM/YY)	Address	City	State	Zip
From - To (MM/YY – MM/YY)	Address	City	State	Zip
From - To (MM/YY – MM/YY)	Address	City	State	Zip
From - To (MM/YY – MM/YY)	Address	City	State	Zip
From - To (MM/YY – MM/YY)	Address	City	State	Zip

Section 7: An MDEG Administrator must provide proof that he or she has least 1,500 hours of verifiable work experience relating to the products provided by the medical products provider or medical products wholesaler. Beginning with the most current, list your hours of employment related to the above. (NAC 639.694)

Business Name			From - To (MM/YY – MM/YY)	
Business Address		City	State	Zip
Phone	Title		Number of Employed Hours	
Description of Duties				

Business Name			From - To (MM/YY – MM/YY)	
Business Address		City	State	Zip
Phone	Title		Number of Employed Hours	
Description of Duties				

Business Name			From - To (MM/YY – MM/YY)	
Business Address		City	State	Zip
Phone	Title		Number of Employed Hours	
Description of Duties				

Business Name			From - To (MM/YY – MM/YY)	
Business Address		City	State	Zip
Phone	Title		Number of Employed Hours	
Description of Duties				

Business Name			From - To (MM/YY – MM/YY)	
Business Address		City	State	Zip
Phone	Title		Number of Employed Hours	
Description of Duties				

Continue on next page if additional space is needed.

Business Name				From - To (MM/YY – MM/YY)	
Business Address		City		State	Zip
Phone	Title			Number of Employed Hours	
Description of Duties					

Business Name				From - To (MM/YY – MM/YY)	
Business Address		City		State	Zip
Phone	Title			Number of Employed Hours	
Description of Duties					

Business Name				From - To (MM/YY – MM/YY)	
Business Address		City		State	Zip
Phone	Title			Number of Employed Hours	
Description of Duties					

Business Name				From - To (MM/YY – MM/YY)	
Business Address		City		State	Zip
Phone	Title			Number of Employed Hours	
Description of Duties					

Business Name				From - To (MM/YY – MM/YY)	
Business Address		City		State	Zip
Phone	Title			Number of Employed Hours	
Description of Duties					

Make copies of this page OR use a separate piece of paper if additional space is needed.

Section 8: Personal and Professional History	Yes	No
1. Have you been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?		
2. Have you been charged, arrested or convicted of a felony or misdemeanor in any state?		
3. Have you been the subject of a board citation or an administrative action whether completed or pending in any state? Include all public or private actions against a professional license, not limited to a suspension, revocation, surrender or other discipline.		

Please use and make copies of this page (if necessary) to provide information as requested below regarding any questions, 1-3, you have marked "YES" to in section 8 of the application. A signed statement of explanation for each event and a copy of all documents that identify the circumstance or contain an order, agreement or other disposition for the event must be provided.

This is in response to Question # ______. Provide all the following *where applicable*:

Date of Event/Arrest	Disposition Date	State	City	County
Case #		Governing, licensing, Arresting Presiding Body/Agency/Court		
Reason/Charge				
Plaintiff/Defendant/Claimant/Respondent			Lawsuit/Arbitration/Bankruptcy	
Name of Business/Industry/Entity				

Provide explanation below:

____ ______________________________

Original Signature (electronic, copies or stamps not accepted) Date

I, ____, certify that as the MDEG Administrator for

____,

that I (initial that you have read and meet the following requirements):

1. ________ Have a high school diploma or its equivalent;
2. ________ Have
   a. At least 1,500 hours of verifiable work experience relating to the products provided by 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;
3. ________ Will be employed by 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
4. ________ Will ensure that the operation of the business or facility complies with all applicable federal, state and local laws, regulations and rules.

I certify under penalty of perjury that the information contained in this application is accurate, true and complete in all material respects. I understand that making any false representation in this application is a crime under NRS 639.281. I understand that, pursuant to NRS 239.010, this entire application and any portion thereof is a public record unless otherwise declared confidential by law, and will be considered by the Nevada State Board of Pharmacy at a public meeting pursuant to NRS 241.020. In the event this application is approved I agree to comply with all applicable federal and state statutes and regulations governing this license or registration and understand that any violation may result in discipline.

____
Print Name (First, Last)

____ ______________________________
Original Signature (electronic, copies or stamps not accepted) Date

Board Use Only	Date Received: ___________________