NEVADA STATE BOARD OF PHARMACY

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

Medical Products Provider- Medical Devices, Equipment and Gases (MDEG) Application

Non-Refundable $500 fee

Rev (06/08/2021)

This application cannot be returned by fax or email.
We must have an original signature and fee to process.

Print and mail the completed application with a **non-refundable fee** of $500.00 paid for by credit or debit card or a check made payable to the **Nevada State Board of Pharmacy**. Credit and debit card payments are charged a **5% processing fee**. Send the completed application to the address indicated on top of this application.

All incomplete applications will be returned. Please ensure all requirements of the application are completed before submission. The deadline date for an application to be considered during a particular board meeting is posted on our website. If a completed application is not received by our office by the deadline, the application will not be considered until the next scheduled board meeting. **Please note that an application received just prior to the deadline date does not guarantee placement on the board agenda.** Upon receipt of a completed application, the application will be placed on the agenda of the next regularly scheduled Board meeting. An appearance before the board may be required. If an appearance is required, you will receive notice of the date and time of the appearance prior to the meeting. For application deadlines and meeting schedule please visit bop.nv.gov.

Any change of ownership, location, or name will require a new application and $500.00 fee.

An MDEG license is renewed in October of even numbered years, regardless of when the license was issued. Fees are not pro-rated.

FOR NEVADA MDEG LOCATIONS: upon application approval or approval of location change, the MDEG location will be required to have a satisfactory inspection by Nevada State Board of Pharmacy personnel before the MDEG provider may operate.

Please access the applicable laws at bop.nv.gov.

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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Where is the facility located? ☐ Nevada ☐ Out-of-State

Type of Application (check applicable box)		**MDEG Business Type (check applicable box)**
☐ New MDEG		☐ Publicly Traded (complete sections 1, 2, 3, 4, 5, 9)
☐ Ownership Change*	* If making a change, provide current license number:	☐ Non-Publicly Traded (complete sections 1, 2, 3, 4, 6, 9)
☐ Name Change*		☐ Partnership (complete sections 1, 2, 3, 4, 7, 9)
☐ Location Change*	M _____	☐ Sole Owner (complete sections 1, 2, 3, 4, 8, 9)

Section 1: General Information

Facility Name: _____

MDEG Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different from physical address): _____

City: _____ State: _____ Zip: _____

Telephone: _____ Website: _____

Email: _____

Name of MDEG Administrator (NAC 639.694): _____

Type of MDEG products that will be sold (check all applicable)

☐ Medical Gases**
☐ Respiratory Equipment**
☐ Life-sustaining equipment**
☐ Parenteral and Enteral Equipment**
☐ Assistive Equipment
☐ Diabetic Supplies
☐ Orthotics and Prosthetics
☐ Others:

** If providing these products, you are required to have in place a mechanism to ensure continued care in the event of an emergency. Provide name and telephone number of Nevada contact (NAC 639.6954):

Name: _____ Telephone: _____

Days and Hours of Operation

Mon:
Tues
Wed:
Thurs:
Fri:
Sat:
Sun:
Holidays:

Section 2: History of Company	Yes	No
1. Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)?		
2. Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration?		
3. Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest ever been subject of an administrative action or proceeding relating to the pharmaceutical industry?		
4. Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances?		
5. Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)?		
If you marked YES to any of the number questions (1-5) above, a signed statement of explanation must be attached. Copies of all documents that identify the circumstance or contain an order, agreement or other disposition for the event must be provided.		

Section 3: List all Medicare and Medicaid provider numbers registered to the business or its owner (NAC 639.6942(4)(i))

Section 4: Are any of the owners a health professional (i.e. Practitioner as defined by NRS 639.0125, Advanced Practice Registered Nurse, Physician's Assistant, Physical Therapist, Occupational Therapist, Registered Nurse, Respiratory Therapist, etc.)? If yes, please provide the name of the owner, their credentials and their percent ownership. (NAC 639.6943, NAC 693.6933)

Name: _____ Credentials: _____ %: _____

Name: _____ Credentials: _____ %: _____

Name: _____ Credentials: _____ %: _____

Name: _____ Credentials: _____ %: _____

Name: _____ Credentials: _____ %: _____

1. The Board will not issue a license to conduct business as a medical products provider or medical products wholesaler to:

   a) A practicing health professional; or

   b) A partnership, corporation or association in which a practicing health professional has a controlling interest or in which ownership of 10 percent or more of the available stock is held by one or more practicing health professionals.

2. As used in this section, "practicing health professional" means a health professional who performs services within the scope of his or her licensure or registration in any capacity in a health care facility other than the facility of the medical products provider or medical products wholesaler.

Section 5: Publicly Traded Corporation

State of Incorporation: _____

Parent Company (if any): _____

Corporation Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

Contact Person Name: _____

Date of SEC Registration:	SEC Registration Number:	Stock Exchange Symbol:

Section 6: Non-Publicly Traded Corporation or Company

State of Incorporation/Organization: _____

Parent Company (if any): _____

Corporation/Organization Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

Contact Person Name: _____

Section 7: Partnership

Partnership Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

Contact Person Name: _____

Section 8: Sole Owner

Owner's Name: _____

Business Name: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

Section 9: Provide all the applicable documents with your application based on your Business Type. Required documents are indicated by an "✓" on the right.	Publicly Traded	Non-publicly Traded	Partner-ship	Sole Owner
• **List of <u>all</u> Officers and Directors.**	✓	✓		
• **List of <u>all</u> general and limited partner names and their percent ownership (NAC 639.6942).**			✓	
• **Certificate of Corporate Status or Certificate of Good Standing** obtained from the Secretary of State's Office in the State where the business is domiciled, dated within the last **6 months**.	✓	✓	✓	✓
• **Medical products provider located outside of this State must submit evidence that the medical products provider is licensed, permitted, registered or otherwise lawfully authorized by the state of residence of the medical products provider to engage in the same business for which the medical products provider is seeking licensure in this State (NAC 639.6944). Provide a copy of the home state license, permit, registration or certification issued to the medical products provider (if applicable).**	✓	✓	✓	✓
• **Copy of proof of insurance (NAC 639.6946).** The MDEG provider shall maintain liability insurance of at least one million dollars ($1,000,000.00).	✓	✓	✓	✓
• **Personal History Record Application** must be completed by each shareholder/stockholder/partner/owner. Find form at http://bop.nv.gov/Services/newapps/Business/		✓	✓	✓
• **MDEG Administrator Application (NAC 639.694).** Find form at http://bop.nv.gov/Services/newapps/Business/	✓	✓	✓	✓

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 of Authorized Person Submitting Application

_____ _____

Original signature of Authorized Person (copies or stamps not accepted) Date

Board Use Only	Date Received: _____ Amount: _____

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, Nevada 89521

(775) 850-1440 • 1-800-364-2081 • FAX (775) 850-1444

• Web Page: bop.nv.gov

Applicant Name: _____

Payment: Pay application fee by providing your credit or debit card information below, or by submitting a check made payable to **Nevada State Board of Pharmacy**. Credit Cards are charged a 5% processing fee		
Credit Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express	**Credit Card #:** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	
Expiration Date: __ __/__ __ (MM/YY	**CVV** (3 digits on back of card): _____	**License Amount**: $_____
Name on Card: _____		
Billing Address: _____ _____ _____		