

APPLICATION FOR REGISTRATION

MEDICAL DEVICE, EQUIPMENT & GAS DRUG OUTLET

(Expires January 31 Annually)

OREGON BOARD OF PHARMACY
800 NE OREGON STREET, SUITE 150
PORTLAND, OR 97232
TELEPHONE (971) 673-0001
www.pharmacy.state.or.us



FOR BOARD USE ONLY [0308] \$50.00

RECEIPT # _____

BATCH DATE _____

ENTERED BY _____

MEDICAL DEVICE, EQUIPMENT & GAS DRUG OUTLET

FEE: \$50.00

ALL FEES ARE NON-REFUNDABLE

- New Outlet Start Date _____
- Owner Change Date Effective _____ Former license number _____
- Location Change Date Effective _____ Former license number _____

A change of ownership or location **requires** the submission of a new application and registration fee within 15 days. Please check the appropriate box regarding application status: Name change only – (no fee required)

Please PRINT or TYPE

WARNING: ORS 475.135 (e) The furnishing of false information is grounds to deny registration.

Business Name _____

Location Address _____

Phone Number () - FAX # () -

City, State, Zip _____

License & Renewal Mailing Address _____

City, State, Zip _____

Contact Person _____ Title _____ Contact Phone _____

Phone Number () - FAX # () -

Federal Tax ID # or Owner SSN: _____ Email: _____

Does this outlet belong to a chain? Yes No

Medicinal Gases/Equipment Sold: _____

Business Ownership: *If owned by a corporation, please complete line 4 below:

- Corporation (Name and address of corporation officers and registered agent.)
- Individual Owner, Trustee or Receiver. (Enter name, title & address below.)
- Partnership (List below names and addresses of the 3 largest share holders.)

NAME	TITLE	MAILING ADDRESS & PHONE
1.		
2.		
*Corporate Name	*Date Organized (if new)	State in which incorporated

PLEASE CHECK ONE:

- I wish to have my registration application processed on the date you receive my COMPLETE APPLICATION and PAYMENT in your office. Because the Oregon Board of Pharmacy does not prorate fees, **I realize that by having my registration become effective before the beginning of the renewal period (February 1) my license will not be valid for a full year.**
- I wish to have my registration become effective on the following February 1st. I realize that I cannot sell any over the counter medications until then. (**ONLY APPLICABLE FOR NEW OUTLETS*)

Signature _____ Title _____ Date _____

MAIL THIS APPLICATION WITH \$50 FEE PAYABLE TO THE OREGON BOARD OF PHARMACY.
ALL RETURNED CHECKS WILL BE ASSESSED A \$35.00 RETURNED CHECK FEE
PURSUANT TO ORS 30.701(5)