



# MAINE BOARD OF PHARMACY

Application information to assist in completing your application. This information is not designed to include all information on laws and rules and it is strongly recommended that you review applicable laws and rules.

## Retail Supplier of Medical Oxygen and Oxygen Devices

Do not return the following informational pages with your application; it is for your information only

Department of Professional and Financial Regulation  
Office of Professional and Occupational Regulation  
(Mailing address) 35 State House Station, Augusta, ME 04333  
(Office location) Gardiner Annex, 76 Northern Avenue, Gardiner, Maine 04345

Office Direct Line (207) 624-8620 or Main Receptionist (207) 624-8603  
TTY users call Maine relay 711  
FAX (207) 624-8637

Web address: [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing)  
Email: [pharmacy.lic@maine.gov](mailto:pharmacy.lic@maine.gov)

### FAQ's

Have a question? Please visit our list of Frequently Asked Questions.

#### **Can I come to Gardiner to drop off my application?**

No, the Gardiner Annex is closed to the public until further notice due to the Covid-19 pandemic. Please mail your paper application to our mailing address  
35 State House Station, Augusta, ME 04333.

## INFORMATIONAL

- ✓ Receipt of your application does not constitute entitlement to do business in Maine. While applications are logged in as ‘pending’ this does not mean a license has been issued. You must hold an active license in order to begin to do business in Maine. Processing time depends greatly on the completeness of your application.
- ✓ Your application has greater chance of being processed expeditiously if it is complete and all supporting documents are attached. Action on this application is posted to the web in real time. Please visit our website if you wish to monitor progress. If the status appears as Pending, this means that your application was received by this office and it is pending or under review. Once reviewed and if everything about your application is complete and complies with requirements, the license will be issued and the status will show as ACTIVE. If incomplete and a letter is being sent to you, the letter will be available for you to see online.
- ✓ Please refrain from calling our office to “check” on your application as these calls only serve to slow our ability to review and process applications. Information regarding the status of applications may be found at the Office of Professional and Occupational Regulation’s website [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing). We appreciate your thoughtful attention to this request.
- ✓ Once your license is issued it is immediately visible online with an “active” status. Licenses are printed off site and require at least 14 business days for delivery.
- ✓ If there is an urgent need to contact us, please be advised that we will only discuss your application with the contact person named in the application to avoid miscommunications. This is done not only for your protection, but to also avoid any complications with too many hands involved, which generally leads to miscommunication or misunderstandings. Our goal is to streamline your process, not complicate it.
- ✓ Incomplete applications or documents that have been modified or altered in any way, including use of a white out substance will not be accepted and will be returned.

## LAW AND BOARD RULE REFERENCE

Information contained in this application is not a substitute for carefully reviewing applicable laws and rules. You may obtain a copy of the laws and board rules online at [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing)—Click on “list of licensed professionals”, click on “Pharmacy” under “Board of Pharmacy Home” click on “Laws & Rules”

Notwithstanding, please pay particular attention to the following:

- 32 MRSA c. 117, Subchapter 5
- Board Rules, Chapter 17

Pursuant to Board Rules, Chapter 34, Section 3:

“The board may issue a temporary license as a retail supplier of medical oxygen upon receipt of an application for licensure submitted pursuant to Section 4 of this chapter. The application must demonstrate the applicant’s prima facie eligibility for licensure. The temporary license expires 90 days from the date of issuance. Within the first 60 days of temporary licensure, a temporary licensee shall complete the application to the satisfaction of the board. The board will act on timely-completed applications for licensure within the 90-day period of the temporary license.”

A temporary license will expire 90 days from the date of issuance. This is not a permanent license. This is solely intended to temporarily approve your application pending completion if it is not complete when initially submitted. If applications are not fully completed to the Boards satisfaction within the 90 day period your application for a permanent license will be denied. **We strongly encourage you to file a fully completed application to avoid processing delays to obtain a permanent license.**



**STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION  
COMPANY APPLICATION**

APPLICANT INFORMATION (please print)			
NAME OF RETAIL SUPPLIER OF MEDICAL OXYGEN AND OXYGEN DEVICES			
FEIN OR SSN			
PHYSICAL LOCATION			
CITY	STATE	ZIP	COUNTY
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # (    )		FAX # (    )	
PERSON RESPONSIBLE FOR COMPLETING AND SUBMITTING APPLICATION (must be an owner or officer of the entity)			
By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Professional and Occupational Regulation will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.			
<b>SIGNATURE</b>		<b>DATE</b>	

**Board of Pharmacy  
Retail Supplier of Medical Oxygen and Oxygen Devices  
Required Fee: \$200.00 (Non-Refundable)**

*Office Use Only:*  
MGD1421 - \$200.00

*Office Use Only:*  
Check # \_\_\_\_\_  
Amount: \_\_\_\_\_  
Cash # \_\_\_\_\_  
Lic. # \_\_\_\_\_  
Issue Date \_\_\_\_\_  
Exp. Date \_\_\_\_\_

**PAYMENT OPTIONS:**

Make checks payable to "Maine State Treasurer" - If you wish to pay by MasterCard or Visa, fill out the following:

NAME OF CARDHOLDER (please print name on card)

I authorize the Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation to charge my        VISA        MASTERCARD        the following amount: \$ \_\_\_\_\_

**I understand that fees are non-refundable**

Card number:

Expiration Date        /       

**SIGNATURE**

**DATE**

**SECTION 1: TYPE OF APPLICATION**

- Initial Application       Change of Ownership       Change of Location

Date of change \_\_\_\_\_

Previous License Number: \_\_\_\_\_  
(this license will be terminated upon issuance of new license)

**Important, please read:** Refer to 32 MRSA §13752, Sec. 3. Please note that a license is not transferrable to another owner or a new location and is subject to a new application and licensure before you begin to operate under new ownership or in a new location.

**SECTION 2: APPLICATION CONTACT PERSON** *(person responsible for completing and submission of application must be an owner or officer of the entity).*

Last Name	First Name	Middle Name
Title		

Name of Retail Supplier of Medical Oxygen and Oxygen Devices	
Facility Telephone Number	Facility Fax Number
(    )	(    )
Facility E-mail Address	Facility Web Address
All Trade Names or Business Names of the Facility	

**INITIALS OF APPLICANT**

**SECTION 3: Person Responsible for Emergency Contact for Operation of the Retail Supplier of Medical Oxygen or Oxygen Devices:**

Last Name	First Name	Middle Name	
Job Title			
Contact Address	City	State	Zip Code
Telephone Number	Emergency Contact Telephone		
(     )			
E-mail Address			

**SECTION 4: Hours of Operation:** Denote am/pm.

Day	Open	Close
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

**SECTION 5: Scaled Drawing of the Facility**

Scaled drawing of the facility which details the usage of each area. Please limit the copy of the scaled drawing plan to an 8x11 or 8x14 paper size if possible. This would include storage area(s) that may or may not be attached to the physical building but is part of the overall facility.

**INITIALS OF APPLICANT**

**SECTION 6: OWNERSHIP.** Please check one and complete the appropriate block below.

- Sole Proprietor (*complete section A*)
- Partnership (*complete section B*) - If your partnership consists of 2 or more corporations, you must submit a list of officers and an organizational chart.
- Corporation (*complete section C*) - If you are a corporation you must submit a Certificate of Existence from the State of origin. For Corporations not organized under Maine law, a Certificate of Authority from the Maine Secretary of State is required. For assistance, call (207) 624-7752. Please be aware the application to file for a certificate of existence is not evidence of having been issued a Certificate of Authority.
- Limited Liability Company (*complete section D*) - If you are a limited liability company, you must submit the names and mailing addresses of each member and manager; a Certificate of Existence from the Maine Secretary of State or, for limited liability companies not organized under Maine law, a Certificate of Authority or Certificate of Qualification from the Maine Secretary of State; and the name of the member or manager who will be representing the applicant in matters before the board.

Section A - Sole Proprietor: (Please type or print legibly)			
Owner Last Name	First Name	Middle Name	
Social Security Number			
Name of Business Entity			
Contact Address	City	State	Zip Code
Telephone Number	Fax Number		
(    )	(    )		
E-mail Address			
Website Address			

**INITIALS OF APPLICANT**

**Section B - Partnership:** List the name and address of each partner (please type or print legibly).  
 Please see Chapter 34, Sec. 4(1)(C)(a) (If you need more space please use separate sheet)

**PARTNERSHIP INFORMATION:**

Name of partnership

Contact Address	City	State	Zip Code
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Telephone Number	FEIN Number
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(      )

E-mail Address

**NAME AND CONTACT INFORMATION OF EACH PARTNER**

<b>Person</b> Last Name	First Name	Middle Name	
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Contact Address	City	State	Zip Code
-----------------	------	-------	----------

E-mail Address	Telephone number
----------------	------------------

(      )

<b>Person</b> Last Name	First Name	Middle Name	
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Contact Address	City	State	Zip Code
-----------------	------	-------	----------

E-mail Address	Telephone number
----------------	------------------

(      )

<b>Company</b> Last Name	FEIN Number
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Contact Address	City	State	Zip Code
-----------------	------	-------	----------

E-mail Address	Telephone number
----------------	------------------

(      )

<b>Company</b> Last Name	FEIN Number
--------------------------	-------------

Contact Address	City	State	Zip Code
-----------------	------	-------	----------

E-mail Address	Telephone number
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(      )

**INITIALS OF APPLICANT**

**SECTION 6 (Continued):**

<b>Section C - Corporation Ownership:</b> Please include an organizational chart. (Please type or print legibly) <i>Please see Chapter 34, Sec. 4(1)(C)(b)</i>			
Name of Corporation			
Assumed Name (d/b/a)			
Name of Parent Company, if any			
FEIN #			
Contact Address of Corporation	City	State	Zip Code
Physical Address of Corporation	City	State	Zip Code
Telephone Number		Fax Number	
(      )			
E-mail Address		Website Address	
Corporate Registration Certificate Number	Issued Under What Jurisdiction	Date	
Contact Address for Registered Agent <i>If different from Corporation</i>	City	State	Zip Code
Physical Address for Registered Agent <i>If different from Corporation</i>	City	State	Zip Code
Telephone Number	E-mail Address/ Website Address		
(      )			

**INITIALS OF APPLICANT**



**SECTION 6-C (Con't): OWNERSHIP** Please see Chapter 34, Sec. 4(1)(C)(b)

Is this corporation's stock traded on a major stock exchange and not over-the-counter

YES

NO

If, no complete the section below—List the name and contact address of each shareholder owning 10% or more of the voting stock of the corporation, including over-the-counter stock. Use a separate sheet of paper if needed.

1. Last Name		First Name		Middle Name	
Address		City		State	Zip Code
E-mail Address			Telephone Number		
			( )		

2. Last Name		First Name		Middle Name	
Address		City		State	Zip Code
E-Mail Address			Telephone Number		
			( )		

3. Last Name		First Name		Middle Name	
Address		City		State	Zip Code
E-Mail Address			Telephone Number		
			( )		

4. Last Name		First Name		Middle Name	
Address		City		State	Zip Code
E-Mail Address			Telephone Number		
			( )		

**INITIALS OF APPLICANT**

**SECTION 6-C (Con't): CORPORATE OFFICER(S) AND DIRECTOR(S)**

1. Last Name	First Name	Middle Name	
Title			
Address	City	State	Zip Code

2. Last Name	First Name	Middle Name	
Title			
Address	City	State	Zip Code

3. Last Name	First Name	Middle Name	
Title			
Address	City	State	Zip Code

4. Last Name	First Name	Middle Name	
Title			
Address	City	State	Zip Code

**INITIALS OF APPLICANT**

**SECTION 6 (Continued):**

<b>Section D - Limited Liability Company:</b>			
(Please type or print legibly)		<i>Please see Chapter 34, Sec. 4(1)(C)(c)</i>	
Name of Limited Liability Company			
Assumed Name (d/b/a)			
Name of Parent Company, if any			
FEIN #			
Contact Address of Limited Liability Company	City	State	Zip Code
Physical Address of Limited Liability Company	City	State	Zip Code
Telephone Number	Fax Number		
(     )			
E-mail Address	Website Address		
Name of Member or Manager Representing Applicant Before the Board			
Mailing Address of Representative	City	State	Zip Code
Telephone Number	E-mail Address		
(     )			
Corporate Registration Certificate Number	Issued Under What Jurisdiction	Date	
Contact Address for Registered Agent <i>If different from Corporation</i>	City	State	Zip Code
Physical Address for Registered Agent <i>If different from Corporation</i>	City	State	Zip Code
Telephone Number	E-mail Address/ Website Address		
(     )			

**INITIALS OF APPLICANT**

**SECTION 6-D (Con't): LIMITED LIABILITY COMPANY** Please see *Chapter 34, Sec. 4(1)(C(c))*

Please list the names and mailing addresses of each member and manager. You may copy this page if more space is needed.

1. Last Name		First Name		Middle Name	
Address		City		State	
E-mail Address			Telephone Number		
			( )		
2. Last Name		First Name		Middle Name	
Address		City		State	
E-Mail Address			Telephone Number		
			( )		
3. Last Name		First Name		Middle Name	
Address		City		State	
E-Mail Address			Telephone Number		
			( )		
4. Last Name		First Name		Middle Name	
Address		City		State	
E-Mail Address			Telephone Number		
			( )		

**INITIALS OF APPLICANT**

## SECTION 7: DISCLOSURE

<p>Have you or has any corporate officers, owners, or the designated officer of this entity <b>ever</b> been convicted of any criminal offense? If yes:</p> <ol style="list-style-type: none"><li>1. Provide a <u>detailed explanation</u> in the offender's own words on a separate sheet of paper.</li><li>2. Attach a copy of the <u>Court Judgment and Decision</u>.</li><li>3. If a motor vehicle criminal offense, attach a copy of a recent motor vehicle report.</li></ol>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Has any state or territory of the U.S., province/territory of Canada, or any other jurisdiction <b>ever</b> denied your application for any type of examination, professional license, certificate or registration, <b>or</b> taken any disciplinary action against the license issued to you in that jurisdiction (including, but not limited to, warning, reprimand, fine, suspension, revocation or restrictions in permitted practice, probation with or without monitoring)? If yes:</p> <ol style="list-style-type: none"><li>1. List the jurisdiction(s) that denied your license or issued discipline and date of action: State/Jurisdiction _____ Date _____ State/Jurisdiction _____ Date _____</li><li>2. <u>Submit a copy of the consent agreement or decision and order for each of the above, with this application.</u></li><li>3. Provide a detailed explanation in your own words on a separate sheet of paper.</li></ol>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Has <u>this entity</u> <b>ever</b> been denied registration by the U.S. Drug Enforcement Administration (DEA) or has this entity <b>ever</b> had a DEA Registration modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked this entity's state permit to prescribe or dispense controlled substances? If yes:</p> <ol style="list-style-type: none"><li>1. DEA action <u>OR</u> Other Entity (Name) _____</li><li>2. Submit a copy of the official action by the entity.</li><li>3. Provide a detailed explanation in your own words on a separate sheet of paper.</li></ol>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Has <u>this entity</u> ever been issued a citation, warning letter or untitled letter by FDA or similar action take by any governmental board?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Have you, the Responsible Person Listed in Section 3, ever received a sanction from Medicare or from a state Medicaid program?</p> <ol style="list-style-type: none"><li>1. Medicare OR Medicaid Program (State) _____</li><li>2. Submit a copy of the official action by the entity.</li><li>3. Provide a detailed explanation in your own words on a separate sheet of paper.</li></ol> <p>Clarification on programs:</p> <ul style="list-style-type: none"><li>• Medicare – Health program administered by the United States government for people that are (1) ages 65 or older, (2) under the age of 65 with certain disabilities, and/or (3) all ages with end-stage renal disease.</li><li>• Medicaid – Health program administered by the United States government for people with limited incomes.</li><li>• MaineCare – Health program administered by the State of Maine with similar eligibility requirements as Medicaid.</li></ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**INITIALS OF APPLICANT**

## **SECTION 8: NOTICES**

### **Change of Ownership, Location or Application Information (Board Rules, Chapter 34, Section 4(5))**

Upon a change of ownership, a retail supplier of medical oxygen shall file a new application with the board no less than 7 days prior to the change. Upon a change of location, a retail supplier of medical oxygen shall file a new application with the board no less than 7 days prior to the change. The licensee shall notify the board of any other change in the information provided on its application within 10 days after the change.

### **Compliance With Current Good Manufacturing Practices (Board Rules, Chapter 34, Section 8)**

Please familiarize yourself with the compliance with current good manufacturing practices.

### **Please Note:**

Pursuant to 10 MRS §8003-G - any change in name, address, email address, criminal convictions, disciplinary actions, or any material change set forth in your original application for licensure must be reported to the Office within 10 days.

You can access this Law for your review at:

<http://www.mainelegislature.org/legis/statutes/10/title10ch901sec0.html>

**INITIALS OF APPLICANT**

**RETAIL SUPPLIER OF MEDICAL OXYGEN AND OXYGEN DEVICES—Checklist affirmation**

Please check mark each box to affirm that you have enclosed the information and documents required for this application. This affirmation checklist does not replace the requirements outlined in the Maine Board of Pharmacy Laws and Rules. Please review them carefully for more detailed and clarifying information. This checklist is designed as a tool to confirm that your application is complete and ready to forward to our office.

CHECKLIST—please checkmark as an indicator that you have completed the following.

- Each section of the application has been completed.
- Each page of the application, where noted at the bottom, has been initialed.
- Signature present where noted.
- Check made payable to: Treasurer State of Maine in the amount of \$200.00 is enclosed, or Credit card authorization completed.
- Entity’s organizational chart.
- A copy of the consent agreement or order issued by the Board or jurisdiction is enclosed if licensure discipline has been indicated.
- A copy of the Court Judgment and Decision is enclosed if convicted of a crime, including a written statement, in the offender’s own words, regarding the details of the crime.
- If you are a corporation, or LLC, you must submit a Certificate of Existence from the State of origin. For entity’s not organized under Maine law, a Certificate of Authority from the Maine Secretary of State is required. For assistance, call (207) 624-7752. Please be aware the application to file for a certificate of existence is not evidence of having been issued a Certificate of Existence.

**SECTION 9: APPLICANT’S CERTIFICATION AND SIGNATURE**

Read the statement below and sign where indicated as your certification of the information provided on this application. Applications that are incomplete, altered (including use of any white out), defaced, or compromised will not be accepted and will be returned. This includes, but not limited to, unanswered questions, lack of appropriate signature, information is illegible, missing required supporting documents, and/or missing or wrong fee.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application I understand that the Maine Board of Pharmacy will rely upon this information for issuance of my license and that this information is truthful and factual. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

Printed Name of Applicant	Title
Signature of Applicant	Date
	