



Division of Public Health
 Licensure Unit
 P.O. Box 94986
 Lincoln, NE 68509-4986

ACCOUNTING
Business Unit #25550345

REQUIRED FEE: \$550

APPLICATION FOR A WHOLESALE DRUG DISTRIBUTOR LICENSE
TO BE USED BY A MEDICAL GAS DISTRIBUTOR

NOTE: This application must be completed by the designated representative. If more space is needed to respond to any question, please attach a clearly identified separate piece of paper.

| | | | |
|--|--|---------------------------|------|
| Name of Business (applicant): | | | |
| Address of Business: | Street/PO Box/Route: | | |
| | City: | State: | Zip: |
| Telephone Number: | | Fax Number: (optional) | |
| E-mail Address: (optional) | | | |
| Type of Business Entity: | | | |
| <input type="checkbox"/> Partnership | Name of each partner: | | |
| | Name of Partnership: | | |
| <input type="checkbox"/> Corporation | Name and title of each corporate officer and director: | | |
| | | | |
| | All corporate names of applicant business: | | |
| | | | |
| <input type="checkbox"/> Sole Proprietorship | State of incorporation: | | |
| | Name of sole proprietor: | | |
| | Name of the sole proprietorship: Social Security Number of sole proprietor: | | |
| Name of Designated Representative: | | | |

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|--|---------------------------------------|--------|------|----------|
| List all trade or business names used by applicant: | | | | |
| | | | | |
| Names of persons in charge and names and addresses for all facilities used by the applicant for storage, handling, and wholesale distribution of prescription drugs: | Name of person in charge of facility: | | | |
| | Street/PO/Route: | | | |
| | City: | State: | Zip: | Phone #: |
| | Name of person in charge of facility: | | | |
| | Street/PO/Route: | | | |
| | City: | State: | Zip: | Phone #: |
| | Name of person in charge of facility: | | | |
| | Street/PO/Route: | | | |
| | City: | State: | Zip: | Phone #: |
| | Name of person in charge of facility: | | | |
| | Street/PO/Route: | | | |
| | City: | State: | Zip: | Phone #: |

Inspection Information:

Inspections will be accepted by the Department if they have been conducted within the six (6) months preceding the date of application or if accreditation status by either a nationally recognized accreditation program or another state or federal agency inspection approved by the Board remains current.

| | | |
|--------------------------|--|---|
| a. | Has your facility been inspected by a nationally recognized accreditation program (example: VAWD) or another state or federal agency within the six (6) months preceding the date of your application? | <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, submit documentation of passing that inspection.</i> |
| | If not inspected by one of these entities within the previous six (6) months, do you hold current accreditation or inspection status from one of these entities? | <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, provide documentation of such current accreditation or inspection status.</i> |
| | If no, identify the entity you wish to conduct the initial inspection: | |
| | <input type="checkbox"/> | Nationally recognized accreditation program (example: VAWD) |
| | <input type="checkbox"/> | Other State Regulatory Agency State and Name of Agency: |
| <input type="checkbox"/> | Federal Regulatory Agency: Name of Agency: | |
| <input type="checkbox"/> | Department (Inspection fee required pursuant to 172 NAC 131-012) | |

| | | |
|----|--|-------|
| 3. | Required Signatures: | |
| a. | Signature of designated representative: | |
| | I attest that I have completed this application and that the statements on this application are true and complete to the best of my knowledge. | |
| | Signature of designated rep: | Date: |
| b. | <u>Lawful Presence in the United States Attestation:</u> | |
| | If the applicant is a <u>sole proprietorship</u> the purpose of complying with Neb. Rev. Stat. §4-108 through 4-114, the applicant must attest as follows: | |
| | <i>Please check the appropriate box below:</i> | |
| | <input type="checkbox"/> I am a citizen of the United States. | |
| | <input type="checkbox"/> I am a qualified alien under the Federal Immigration and Nationality Act. | |
| | My immigration and alien number are as follows: _____ and I agree to provide a copy of my USCIS | |
| | I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States. | |
| | I also attest that the statements on this application are true and complete to the best of my knowledge. | |
| | One of the following: | |
| | (1) If applicant is an individual or partnership, signature owner: | |
| | Signature of owner: | Date: |
| | (2) If applicant is a limited liability company with two members or less, signature of one member. | |
| | Signature of member: | Date: |
| | (3) If applicant is a limited liability company with more than two members, signature of two or more members. | |
| | Signature of member: | Date: |
| | Signature of member: | Date: |
| | (4) If applicant is a corporation, signature of two officers: | |
| | Signature of officer: | Date: |
| | Signature of officer: | Date: |