



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF PHARMACY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR MEDICAL GAS DISPENSER LICENSE INSTRUCTION SHEET

When to File Application

This is the application for licensure of a facility that sells medical gases **directly to patients** in Delaware. However, if you are a facility that **distributes** medical gases to other facilities authorized to possess medical gases, instead of selling directly to patients, the correct application form is [Application for Distributor \(Pharmacy-Wholesale\)](#).

File this application when applying for an initial license as a Medical Gas Dispenser OR re-applying when a previous Delaware license has lapsed and is no longer renewable. Since these licenses are not transferable, you must also file this application to report when a Medical Gas Dispenser already licensed in Delaware:

- Changes ownership (controlling interest), or
- Relocates

Requirements for All Applicants

Please read and follow instructions carefully. Failing to follow instructions will delay processing of your application.

- Submit completed, signed and notarized [Application for Medical Gas Dispenser License](#).
 - Applications that are incomplete, unsigned or not notarized will be rejected.
- Enclose non-refundable [processing fee](#) by check or money order made payable to the "State of Delaware."
 - Applications submitted without the required fee will be rejected.
- Enclose *Medical Gas Dispenser Permit–Information about Ownership* forms for **all** of the following:
 - Designated Representative (DR) or most senior person responsible for facility operations, purchasing, and inventory control
 - Supervisor of the DR or most senior person responsible for facility operations, purchasing and inventory control
 - If the distributor is not a publicly held company, **all** principals and owners who directly or indirectly own more than 10% interest in the company
- Each person who is required to complete a *Medical Gas Dispenser Permit–Information about Ownership* form must also complete a *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks.
- Enclose one set (copy) of the plans for the dispenser facility.
 - Plans must be drawn to scale and should show the area where medical gases will be dispensed, storage area, all entryways and security systems.
 - Plans must also show the type of alarm system installed and the name, address, and phone of the provider.

Inspection Requirement

In addition to meeting all the requirements above, medical gas dispenser facilities that are located in Delaware must be inspected before opening. A representative of the Delaware facility **must notify the Board office** when the facility is ready for inspection. When the facility passes the final inspection, the Board office will issue the license.

Reporting a Name Change

If the medical dispenser facility's name changes but **there is no change in ownership nor location**, it is not necessary to submit an *Application for Medical Gas Dispenser License*. Instead, submit:

- Letter notifying the Board of the change that includes the dispenser's old name, new name, license number and effective date of change.
- [Duplicate license fee](#) by check or money order made payable to the "State of Delaware."
 - The duplicate license will show the new name, but the license number will not change.



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BOARD OF PHARMACY

For Board of Pharmacy Use Only	
<input type="checkbox"/>	Verification
<input type="checkbox"/>	Background
<input type="checkbox"/>	Office Approval
<input type="checkbox"/>	Inspection

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APPLICATION FOR MEDICAL GAS DISPENSER LICENSE

TYPE OF APPLICATION

1. Select the items that describe the type of application:

- Initial Application –
- This dispenser has never held a Delaware license.
 - This dispenser previously held Delaware license number **A2-** _____ that has lapsed and is no longer renewable.
- Application Due to Change of Ownership – Pharmacy license number **A2-** _____
- Application Due to Relocation – Pharmacy license number **A2-** _____

CONTACT AND LOCATION INFORMATION

2. Name of Business (as it should appear on license): _____

3. Enter all other trade or business names you use (or have used) such as “doing business as” or “formerly known as” names: _____

4. **Location Address:** _____
Street (No PO Boxes) Note: If you are reporting relocation, this is the *new* location.

City State Zip

5. Phone: _____ Email: _____

6. **Mailing Address** (*if different from physical location*): _____

City State Zip

7. Name of Person in Charge: _____ Owner Manager Other

INFORMATION ABOUT OWNERSHIP

8. Form of Business (check one): Corporation Partnership Sole Proprietorship
 Individual with federal employee identification number

9. Enter the name of the Designated Representative (DR) or most senior person responsible for facility operations, purchasing, and inventory control: _____

Enclose a *Medical Gas Dispenser Permit–Information about Ownership* form for this person. This person must also complete a *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks.

10. Enter the name of the supervisor of the person named above: _____ **Enclose a *Medical Gas Dispenser Permit–Information about Ownership* form for this person. This person must also complete a *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks.**

11. Is this business a publicly held company? Yes No **If no, list the names of the principals and owners who directly or indirectly own more than 10% interest in the company.**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Enclose a *Medical Gas Dispenser Permit–Information about Ownership* form for each person listed. Each person listed must also complete a *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks.

12. Do you understand that the Board must be notified within ten days of a change of ownership? Yes No

PERSONNEL INFORMATION

13. Enter the following information about **all healthcare professionals** who will review verbal orders within 72 hours:

FULL NAME	DELAWARE LICENSE NUMBER

14. Have all personnel dispensing medical gases been trained to comply with the standards dictated by the U.S. Pharmacopoeia, Food and Drug Administration, Department of Transportation, Occupational Safety and Health Administration, Board of Pharmacy and any other applicable requirement under state and federal law or rules and regulations regarding storage, packaging, labeling, shipping, dispensing, transfilling, distributing and repackaging of medical gases? Yes No

INFORMATION ABOUT SITE AND OPERATION

15. Enter Hours of Business Site:

Weekdays	_____	A.M. to	_____	PM
Saturday	_____	A.M. to	_____	PM
Sunday	_____	A.M. to	_____	PM
Holidays	_____	A.M. to	_____	PM

16. The storage and handling requirements of medical gases must follow the manufacturer’s labeling requirements. Will the dispenser meet this requirement? Yes No

17. Labeling of dispensed gases must include the manufacturer’s label and a lot number on the cylinder in accordance with the federal Food, Drug and Cosmetic Act. Will the dispenser meet this requirement? Yes No

18. Do the floor plans for the facility include the type of alarm system installed and the name, address, and phone number of the provider? Yes No

19. The dispenser must maintain:
- original of every order for a period of at least three years after the date of last dispensing
 - patient records that include at a minimum
 - name, address and phone of patient
 - name, address and phone of licensed practitioner
 - item and quantity dispensed
 - dispensing date

Will the dispenser meet these recordkeeping requirements? Yes No

Enclose a copy of the plans for the dispenser facility. Plans must be drawn to scale and should include the location of storage area, security systems, and all entryways.

When your application is complete, please allow 4-8 weeks to receive your permit. A complete application is one that includes all required documentation and correct payment. Applications that are not complete within 12 months of filing may be considered abandoned and discarded.

AFFIDAVIT

I hereby swear or affirm that the foregoing statements are correct and do hereby agree to abide by the pharmacy laws of the State of Delaware and to all rules and regulations of the Delaware State Board of Pharmacy.

Signature: _____ Date: _____

Print Name: _____ Position: _____

State: _____ County: _____

Sworn or affirmed before me a Notary Public this _____ day of _____, 2_____

Notary Public: _____

SEAL

My commission expires on _____

APPLICATIONS THAT ARE NOT SIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.



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MEDICAL GAS DISPENSER PERMIT—INFORMATION ABOUT OWNERSHIP

INSTRUCTIONS

Complete and submit one of these forms for each of the following persons listed on the *Application for Medical Gas Dispenser Permit*:

- Designated Representative (DR) or most senior person responsible for facility operations, purchasing, and inventory control
- Supervisor of the DR or most senior person responsible for facility operations, purchasing and inventory control
- If not a publicly held company, *all* principals and owners who directly or indirectly own more than 10% interest in the company

Each person completing one of these forms must also complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks.

1. Name of Medical Gas Dispenser: _____
2. Name: _____
Last Name First Name Middle
3. Type of Interest in Medical Gas Dispenser Named Above (check one):
 Sole Proprietor Partner Individual with federal employee identification number
 Corporate Officer – Position: _____
 Designated Representative Designated Representative's Supervisor
4. Social Security Number: _____ Date of Birth: _____
5. Mailing Address: _____
City State Zip
6. Phone: _____ Email: _____
7. Has any state or federal agency taken any type of disciplinary action against you or is any such action pending?
Yes No **If yes, enclose a list of all disciplinary actions by state and federal agencies against you.**
8. Have you ever been arrested, interviewed, interrogated, convicted, received a criminal summons, received a civil citation by any police/law enforcement agency, college/university or campus police or security agency? **Note:** This includes DUI's and all juvenile arrests and cases even if dismissed for any reason whatsoever. The *only* exceptions are minor traffic citations. Yes No **If yes, list each charge separately below and give details on a separate page.**

ARREST DATE	ORIGINAL CHARGE	LOCATION OF ARREST (city and state)	ARRESTING POLICE DEPARTMENT	DISPOSITION (e.g., guilty, not guilty, dismissed, etc.)

9. Has a criminal indictment, information, or complaint ever been returned against you, but for which you were not arrested or which you were named as an un-indicted co-party? Yes No **If yes, give details on a separate page.**
10. Have you ever received a pardon or expungement for any criminal offense? Yes No **If yes, give details on a separate page. Include the charge, date, city, county and state.**
11. Have you ever been, or are you now, on parole/probation to any court? Yes No **If yes, give details on a separate page. Include the charges, the name of your parole/probation officer, location including city, county and state where probation was/is served.**
12. Have you ever been civilly or criminally subpoenaed to appear to testify before a federal, state or county grand jury, board or commission? Yes No **If yes, give details on a separate page. Include the location and reason for being subpoenaed.**
13. Have you ever been civilly or criminally subpoenaed to appear to testify before a federal, state or county grand jury, board or commission? Yes No **If yes, give details on a separate page. Include location and reason for being subpoenaed.**

Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow instructions on the form for submitting fingerprints. The State Bureau of Identification will send the reports directly to the Board office.

AFFIDAVIT

I solemnly swear and affirm that the answers to the questions set forth in this application are true and correct.

Signature: _____ **Date:** _____

State of _____ Country of _____

Subscribed and sworn to before me this _____ day of _____, 20_____

Witness my hand and seal hereunto attached.

SEAL

Notary Signature: _____

My Commission expires: _____

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See [Title 28, CFR 16.34](#) for the procedure to obtain a change, correction or update in the FBI record.

Locations

Kent County – Primary Facility

State Bureau of Identification
Blue Hen Mall & Corporate Center
655 S. Bay Rd. Suite 1B
Dover, DE 19901

Walk-ins accepted: Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility

State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(between Rts. 72 and 896 on Rt. 40)

By appointment only

Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility

Thurman Adams State Service Center
546 S. Bedford Street, Rm. 202
Georgetown DE 19947
(across from DeIDOT & Troop 4)

By appointment only

Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.
2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of \$65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. **Personal checks are not accepted in any county.** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a [FD-258 fingerprint form](#) available on the FBI website at www.fbi.gov – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.
2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.
3. **Mail** the *Authorization* form, fingerprint card, and *certified* check or money order (**personal checks are not accepted**) for \$65.00 made payable to “Delaware State Police” to:

**Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430**

DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.

DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.

⇒ ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.



AUTHORIZATION INFORMATION

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CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

Please print or type all information in black ink.

Check the type of license for which you are applying:

- Adult Entertainment
- Charitable Gaming Vendor
- Chiropractic
- Dental
- Funeral
- Massage
- Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM))
- Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)
- Nursing (RN, LPN, APRN)
- Nursing Home Administrator
- Occupational Therapy
- Optometry
- Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
- Physical Therapy/Athletic Trainer
- Podiatry
- Psychology
- Real Estate Appraiser (includes Appraisal Management Company)
- Speech/Hearing
- Social Work
- Texas Hold'em Individual

Print your current full name:

Last Name	First Name	Middle Initial	Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date:** _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

**Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A**

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.