



# Alabama State Board of Pharmacy New Manufacturer/Wholesale Distributor of Oxygen Application

Date Received

Office Use Only

- Please be sure that you have reviewed the license type definitions and selected the proper new application.
- Application **must be signed by the owner, officer, or CEO only**. Power of Attorney's will not be accepted.
- Follow all directions completely as failure to submit required documentation will cause delays in processing your new application.
- You must submit all required documentation with the application packet. Forms will not be pulled from other applications. Incomplete submissions could result in withdrawal of your application. **Application fees are non-refundable.**
- If additional forms are needed, please make copies. If additional space is required to answer a question, please attach the information on a separate sheet of paper.
- Section A is the **check list**. The documents listed are required for submission with the new application packet. All applicants must comply, or the application will be returned.
- Additional information may be requested through a deficiency email based on information provided on the application. This is part of our detailed comprehensive review process. The applicant will have **30 days from the date of the email** to comply to the deficiency email. If compliance is not met within 30 days, then the application will be considered abandoned and the application will be withdrawn, and no refunds will be issued. If the applicant complies, the documents will be reviewed, then a permit will be issued, or another deficiency email will be issued for additional information. Again, this is part of our comprehensive review process. Multiple deficiency emails could be submitted during a review process. Due to the volume of applications received, weekly status reports will not be possible.
- Section B is **Ownership** and is based on the answer chosen in Section 6 of the application. For Example: If the selection is D, Corporation, then you would refer to Section B – F and provide the forms in Section D, for Corporation. Under each form are the instructions and additional information required to complete this section. This process is the same for section B – F. The applicant may print or copy the "Individual History Affidavit Form" and "Business History Affidavit Form" as many times as applicable.

**Mail Completed Applications to:**  
**Alabama Board of Pharmacy**  
**111 Village Street**  
**Birmingham, AL 35242**

## I. Check List (Section A) Required for All Applicants

---

All applicants **must** complete and submit the following documents:

- Completed New **Manufacturer/Wholesale Distributor of Oxygen Application**
- Proof of entity (foreign or domestic) registration with the Alabama Secretary of State.** [www.sos.state.al.us](http://www.sos.state.al.us)
- Payment Form and check if applicable (Application fees are non-refundable)**
  - New Permit Fee \$750
- Facility Designated Representative** (Section 5 of application)
  - This must be a person of authority that works at the applicant facility.
  - An **Individual History Affidavit Form** must be completed for this person.
- Copy of Home State License\***
  - This must be a copy of the actual certificate.
  - If your state does not require your facility to have a license, provide proof of exemption.
- Verification of the Home State License\***
  - This can be a current online verification from the home state issuing agency, but the printed verification should be within the past 30 days.
  - Verifications mailed directly to our office from other regulatory agencies will not be accepted. The verification must be submitted with all other required documentation as part of the original submission.
  - If your state does not require your facility to have license, provide proof of exemption.
- Proof of registration with the Food and Drug Administration**
  - Manufacturers of Oxygen must be reporting to the FDA Drug Establishments Current Registration Site and provide their FDA FEIN.
  - If you are wholesale distribution only there is currently no FDA requirement.
- Application Contact Form**
  - One contact per new application only.

\*Not required for in state applicants

**II. Ownership: Section B-F is based on the answer chosen in Section 6 of the application.**

**(Section B) Individual Owner**

---

**Individual History Affidavit Forms**

Complete one form for Owner(s) listed in section 6 of the application.

**Business History Affidavit Forms**

Complete one form for the Applicant Business.

**(Section C) Partnership**

---

**Individual History Affidavit Forms**

Complete one form for each Partner/Authorized Agent listed in section 6 of the application.

**Business History Affidavit Forms**

Complete one form for the Applicant Business and any Entity Owner listed in section 6 of the application.

**Partnership Agreement**

Current executed agreement

**(Section D) Corporation**

---

**Individual History Affidavit Forms**

Complete one form for each owner, officer, stockholder, and executive officer listed in section 6 of the application.

**Business History Affidavit Forms**

Complete one form for the Applicant Business and any Entity Owner listed in section 6 of the application.

**Ownership Organizational Chart**

Provide an organizational chart that clearly outlines the company's ownership structure and includes percentages for each party.

**(Section E) Publicly Traded Corporation**

---

**Individual History Affidavit Forms**

Complete one form for each executive officer and any authorized agent listed in section 6 of the application.

**Business History Affidavit Forms**

Complete one form for the Applicant Business and any Entity Owner listed in section 6 of the application.

**(Section F) Limited Liability Company**

---

**Individual History Affidavit Forms**

Complete one form for each member, executive officer, and authorized agent listed in section 6 of the application.

**Business History Affidavit Forms**

Complete one form for the Applicant Business and any Entity Owner listed in section 6 of the application.

**Ownership Organizational Chart**

Provide an organizational chart that clearly outlines the company's ownership structure and includes percentages for each party.



# Alabama State Board of Pharmacy New Manufacturer/Wholesale Distributor of Oxygen Application

Date Received
Office Use Only

### 1. Applicant Business Details

Name of Business:			
All other trade or business names ("DBA" names) used by applicant:			
Business Address: <i>Number and Street</i>			
<i>City</i>	<i>State</i>	<i>Zip</i>	<i>County (If in Alabama)</i>
Telephone Number for Business:		Federal Employer Identification Number/TIN:	
FDA Federal Establishment Identification Number:		<input type="checkbox"/> Wholesale Distribution Only.	

### 1. Hours of Operations

<i>Monday - Friday</i>	<i>Saturday</i>	<i>Sunday</i>
------------------------	-----------------	---------------

### 2. Business Operations

<b>2a. The Applicant Business will provide oxygen to: (Mark all that apply)</b>  <input type="checkbox"/> Community pharmacies <input type="checkbox"/> Hospitals/Nursing Homes <input type="checkbox"/> Wholesale Distributors <input type="checkbox"/> Licensed Medical Providers Office <input type="checkbox"/> Repackagers  <input type="checkbox"/> Other: _____
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

### 3. Discipline/Settlement/FDA 483/Warning

Has any final judgment been entered or settlement reached resulting from a claim or action for damages caused by any error, omission or negligence in the performance of any pharmacy or pharmaceutical professional services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has this business ever surrendered, had suspended or lost its license or received any other disciplinary action?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the applicant ever received a FDA 483, warning letter, recall, or seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**3a. If you answered "yes" to any of the above questions attach a copy of the official documents and an explanation to the application.**

### 4. Facility Designated Representative: This must be a person of authority that work at the applicant's facility.

**4a. In addition, an Individual History Affidavit Form must be completed for this person.**

Name	Date of Birth	Social Security Number
Title	Email	
Phone Number	Home Address: <i>Number and Street</i>	
<i>City</i>	<i>State</i>	<i>Zip</i>

**5. Ownership:** *Section B-F is based on the answer chosen in Section 6 of the application.*

Ownership details must be provided for the applicant business. These details may include a parent company, and officers, partner, or members (as appropriate) for the business. (See section B – F)

<b>Type of Ownership:</b>  <input type="checkbox"/> Individual Owner <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation (Not publicly traded) <input type="checkbox"/> Publicly Traded Corporation  <input type="checkbox"/> Limited Liability Company
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**6a. Entity Owners**

If the applicant business is owned by an entity (not a natural person), the applicant must identify each parent company that has 10% or more ownership.

<b>Name</b>	<b>FEIN/TIN#</b>	<b>% of Ownership</b>	<b>Phone Number</b>
<b>Address:</b> <i>Number and Street</i> <i>City</i> <i>State</i> <i>Zip</i>			
<b>Authorized Agent</b>		<b>Authorized Agent Phone Number:</b>	

<b>Name</b>	<b>FEIN/TIN#</b>	<b>% of Ownership</b>	<b>Phone Number</b>
<b>Address:</b> <i>Number and Street</i> <i>City</i> <i>State</i> <i>Zip</i>			
<b>Authorized Agent</b>		<b>Authorized Agent Phone Number:</b>	

<b>Name</b>	<b>FEIN/TIN#</b>	<b>% of Ownership</b>	<b>Phone Number</b>
<b>Address:</b> <i>Number and Street</i> <i>City</i> <i>State</i> <i>Zip</i>			
<b>Authorized Agent</b>		<b>Authorized Agent Phone Number:</b>	

**6b. Natural Person Ownership**

Complete the details below for each owner, partner, member and/or stockholder (as appropriate) with 10% or more ownership that is a natural person owner for this business.

<b>Name</b>	<b>Title</b>	<b>Date of Birth</b>	<b>Social Security Number</b>
<b>Address:</b> <i>Number and Street</i> <i>City</i> <i>State</i> <i>Zip</i>			
<b>Phone Number</b>	<b>Email Address</b>		<b>% of Ownership</b>

<b>Name</b>	<b>Title</b>	<b>Date of Birth</b>	<b>Social Security Number</b>
<b>Address:</b> <i>Number and Street</i> <i>City</i> <i>State</i> <i>Zip</i>			
<b>Phone Number</b>	<b>Email Address</b>		<b>% of Ownership</b>

<b>Name</b>	<b>Title</b>	<b>Date of Birth</b>	<b>Social Security Number</b>
<b>Address:</b> <i>Number and Street</i>		<i>City</i>	<i>State</i> <i>Zip</i>
<b>Phone Number</b>	<b>Email Address</b>		<b>% of Ownership</b>

**6c. Executive Officer(s):**

Complete the details for each executive officer for the business. At a minimum you must include the President/CEO, Vice President, Secretary, and Treasurer.

<b>Name</b>	<b>Title</b>	<b>Date of Birth</b>	<b>Social Security Number</b>
<b>Address:</b> <i>Number and Street</i>		<i>City</i>	<i>State</i> <i>Zip</i>
<b>Phone Number</b>	<b>Email Address</b>		

<b>Name</b>	<b>Title</b>	<b>Date of Birth</b>	<b>Social Security Number</b>
<b>Address:</b> <i>Number and Street</i>		<i>City</i>	<i>State</i> <i>Zip</i>
<b>Phone Number</b>	<b>Email Address</b>		

<b>Name</b>	<b>Title</b>	<b>Date of Birth</b>	<b>Social Security Number</b>
<b>Address:</b> <i>Number and Street</i>		<i>City</i>	<i>State</i> <i>Zip</i>
<b>Phone Number</b>	<b>Email Address</b>		

<b>Name</b>	<b>Title</b>	<b>Date of Birth</b>	<b>Social Security Number</b>
<b>Address:</b> <i>Number and Street</i>		<i>City</i>	<i>State</i> <i>Zip</i>
<b>Phone Number</b>	<b>Email Address</b>		

**In signing, the MANUFACTURER/ WHOLESALER DISTRIBUTOR OF OXYGEN applicant agrees to:**

- Provide names of trading partners, suppliers and purchasers, when requested.
- Comply with federal and state regulations regarding import and export regulations.
- Assist and cooperate with state of Alabama inspections/investigations regarding operation of businesses and facility (s) covered by this application.

***It is affirmed that all information provided herein is true and correct and it is recognized that providing false information may result in disciplinary action. It is understood that there must be compliance with the provisions of the Alabama Pharmacy Act, the Rules of the Board and all other applicable statutes and rules.***

\_\_\_\_\_  
Signature Owner, Officer, or CEO only

\_\_\_\_\_  
Title

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**Are you a US Citizen? YES NO If NO, Submit documentation of legal status in this country.**

**FORM MUST BE NOTARIZED**

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_ A.D.

APPLICATION MUST BE NOTARIZED

\_\_\_\_\_  
Notary Public (seal)



# INDIVIDUAL HISTORY AFFIDAVIT FORM

Date Received
Office Use Only

Name: <i>First</i> <i>MI</i> <i>LAST</i>			Date of Birth:
Social Security Number:	Telephone Number:	Email Address:	
Home Address: <i>Number and Street</i>		<i>City</i>	<i>State</i> <i>Zip</i>

Company Name:	Permit Number:
Company Address: <i>Number and Street</i>	<i>City</i> <i>State</i> <i>Zip</i>

Position with Business: *(Check all that apply)*

Owner  
 Partner  
 Officer  
 Stockholder  
 Member  
 Designated Representative

Other: Specify \_\_\_\_\_

Provide details for any professional or vocational license held in the past five years. (Pharmacist, physician, dentist, veterinarian attorney, accountant etc.)

License Held	State Issued	License Number

1.	Have you ever been an owner, partner, officer, or member of any business (partnerships, corporation, firm, or association) whose license was denied, revoked, suspended, surrendered or placed on probation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever had any professional or vocational (e.g. pharmacist, technician, pharmacy) license/registration revoked, suspended, denied, suspended, placed on probation or any other disciplinary action by any Federal or State authority?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you ever been arrested and/or convicted of a felony or misdemeanor (excluding minor traffic violations that do not involve drugs or alcohol) in any state?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Has any final judgment been entered or settlement reached resulting from a claim or action for damages caused by any error, omission or negligence in the performance of any pharmacy or pharmaceutical professional services?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "Yes" to any of the above questions you must attach an explanation that includes the date, license type, license number, your position, state issued, and a copy of any arrest records, board orders, or court proceedings.

***It is affirmed that all information provided herein is true and correct and it is recognized that providing false information may result in disciplinary action. It is understood that there must be compliance with the provisions of the Alabama Pharmacy Act, the Rules of the Board and all other applicable statutes and rules.***

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**FORM MUST BE NOTARIZED**

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ A.D.

APPLICATION MUST BE NOTARIZED \_\_\_\_\_

Notary Public (seal)





# NEW BUSINESS HISTORY AFFIDAVIT FORM

Date Received
Office Use Only

Permit Holder (Business) Name:	Permit Number:
Company Address: <i>Number and Street</i>	<i>City</i> <i>State</i> <i>Zip</i>

Name of Entity Owner:	FEIN/TIN#
Address: <i>Number and Street</i>	<i>City</i> <i>State</i> <i>Zip</i>
Name of Authorized Agent:	Phone Number:
Authorized Agent's Position: <input type="checkbox"/> Owner <input type="checkbox"/> Member <input type="checkbox"/> Manager <input type="checkbox"/> Principal <input type="checkbox"/> Executive Director	

1.	Has this business ever been an owner, partner, officer, or member of any business (partnerships, corporation, firm, or association) whose license was denied, revoked, suspended, surrendered or placed on probation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Has this business ever been in violation of any part of the Alabama Pharmacy Law or its regulations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Has this business ever been charged and/or convicted of violating any Federal or U.S. State law?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Has any final judgment been entered or settlement reached resulting from a claim or action for damages caused by any error, omission or negligence in the performance of any pharmacy or pharmaceutical professional services?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered Yes to any of the above questions you must attach an explanation that includes the date, license type, license number, your position, state issued, and a copy of any arrest records, disciplinary orders, or court proceedings.

*It is affirmed that all information provided herein is true and correct and it is recognized that providing false information may result in disciplinary action. It is understood that there must be compliance with the provisions of the Alabama Pharmacy Act, the Rules of the Board and all other applicable statutes and rules.*

\_\_\_\_\_  
Signature Owner, Officer, or CEO only

\_\_\_\_\_  
Title

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**FORM MUST BE NOTARIZED**

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ A.D.  
APPLICATION MUST BE NOTARIZED

\_\_\_\_\_  
Notary Public (seal)



# Application Contact Person

Date Received
Office Use Only

## Applicant Business Information

<i>Name of Business:</i>			
<i>Address of Business: Number and Street</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>

Please provide the best contact details for the person to be contacted regarding any deficiencies, questions, or concerns regarding this application. All official correspondence regarding this application will be directed to this individual only.

<i>Name:</i>	<i>Telephone Number:</i>		
<i>Mailing Address: Number and Street</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
<i>Email Address:</i>			

\_\_\_\_\_  
Signature Owner, Officer, or CEO only

\_\_\_\_\_  
Title

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date



Date Received
Office Use Only

# PAYMENT FORM

You may pay by check or credit card. Please denote below which method of payment you will be sending.

Business Name: \_\_\_\_\_ Permit # \_\_\_\_\_

Check # \_\_\_\_\_ is attached – Please make check payable to the Alabama State Board of Pharmacy

Charge fees to credit card (There will be an additional 5% transaction fee)

Credit Card Type: Visa MasterCard Discover American Express (please circle)

Card Number: \_\_\_\_\_

Expiration Mo/Yr: \_\_\_\_\_ / \_\_\_\_\_ (MM/YY)

Security Code \_\_\_\_\_

Card Holder Name: \_\_\_\_\_

Complete Billing Address: \_\_\_\_\_

\_\_\_\_\_  
 (City) (State) (Zip)

Signature of Card Holder \_\_\_\_\_

**MUST be Signature of Card Holder**

If you need a transaction receipt, please provide an email address.

\_\_\_\_\_