Make Check Payable To:
Treasurer – State of NH

$250.00

State of New Hampshire
Board of Pharmacy
121 South Fruit Street, Ste 401
Concord, NH 03301-2412
Tel (603) 271-2350 Fax (603) 271-2856
www.oplc.nh.gov/pharmacy

LIMITED RETAIL DRUG DISTRIBUTOR
METHADONE MAINTENANCE / DETOXIFICATION FACILITY

(NH Department of Health and Human Services Certified Alcohol / Drug Disorder Treatment Provider)

Clinic Name & Address: ***(Actual Licensed Location)***

_____
Clinic Name

_____
Mailing Address

_____
Street Address

_____
City *State* *Zip Code*

Telephone:	Fax:	DEA Registration # **(Attach Copy)**

Parent Company (If Applicable):

Controlled Substances On Site:	Current NH HHS Certified Drug Treatment Provider Certificate #:	Security: ☐ Audible ☐ Motion
☐ Methadone ☐ Other: _____ ☐ Buprenorphine _____	**(Attach Copy)**	Signal To:

Applicant's Proposed Drug Activity: **(To bona fide patients of clinic only)**	Drug Supply: ☐Bulk ☐ Prepackaged*
☐ Administer ☐ Dispense	*Prepackaged By: _____
☐ Take Home-Available ☐ Methadone ☐ Buprenorphine	Location:_____

Name Of Owner(s)/Individual, Partners or If Corporation, Show Name, Address, Title Of Officers. Attach Additional Sheet If Necessary

Name	Address	Title
Name	Address	Title

Has registration or licensure previously granted to the applicant by any state or federal agency, ever been suspended or revoked? ☐ Yes ☐ No (If "yes", attach a detailed description, dated and signed).

Provide the information below for the person responsible for the operation of the clinic: (The permit & future renewals will be directed to this person)

Name:	Title:	Tel. #:

Business Mailing Address:

Hours of Operation

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Provide name(s) of person(s) in charge of drug purchasing, dispensing records and security. (Use Reverse Side if Necessary)

Medical Director: **Lic #**

Name	Address	Telephone Number

APPLICATION CONTINUED ON NEXT PAGE

Practitioners: (Use Reverse Side If Necessary)			
Name:	Title:	Name:	Title:

Consultant Pharmacist:		
Name	**Consultant's Signature** (Applications without consultant's signature will be returned unprocessed)	NH License No.

Declaration And Signature By Clinic Representative:

I have attached the following <u>required</u> documents:

- ❑ A copy of the clinic's *Current NH DHHS Certified Drug Treatment Provider Certificate.*
- ❑ A copy of the clinic's current *DEA Registration.*
- ❑ A copy of the certificate of working security alarm.

I declare under penalties of perjury that this application (including any accompanying documents) has been examined by me and to the best of my knowledge and belief is a true, correct and complete application, and if the permit herein applied for is granted, I hereby agree to and do submit to the jurisdiction of the New Hampshire Board of Pharmacy and to the laws and rules of this State. To the best of my knowledge, myself nor any of the employees, listed on this application, have been arrested, investigated for, charged with, convicted of, sentenced, entered a plea of non contendere, or entered into any other legal agreements for any criminal offense in any state, territory or possession of the United States or by the federal government.

Signature: _____ Title: _____ Date: _____

(Responsible Party) ***(Indicate whether owner, partner, or officer of corporation)***

THE LICENSEE SHALL NOTIFY THE BOARD WITHIN 15 DAYS, IN WRITING, OF ANY CHANGES IN THE INFORMATION CONTAINED IN THIS APPLICATION.

Incomplete Applications will be returned