



State of New Hampshire
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
DIVISION OF LICENSING AND BOARD ADMINISTRATION
 7 Eagle Square, Concord, NH 03301-2412
 Phone: 603-271-2152

LIMITED RETAIL DRUG DISTRIBUTOR
METHADONE MAINTENANCE / DETOXIFICATION FACILITY
 (NH Department of Health and Human Services Certified Alcohol / Drug Disorder Treatment Provider)
Application Fee \$500.00

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: <input type="checkbox"/> Methadone <input type="checkbox"/> Other: _____ <input type="checkbox"/> Buprenorphine _____			Current NH HHS Certified Drug Treatment Provider Certificate #: _____ (Attach Copy)		Security: <input type="checkbox"/> Audible <input type="checkbox"/> Motion Signal To: _____	
Applicant's Proposed Drug Activity: (To bona fide patients of clinic only) <input type="checkbox"/> Administer <input type="checkbox"/> Dispense <input type="checkbox"/> Take Home-Available <input type="checkbox"/> Methadone <input type="checkbox"/> Buprenorphine				Drug Supply: <input type="checkbox"/> Bulk <input type="checkbox"/> Prepackaged* *Prepackaged by: _____ 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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:						
Name _____		Address _____		License # _____		Telephone Number _____

APPLICATION CONTINUED ON NEXT PAGE

Practitioners: (Use Reverse Side If Necessary)			
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 required 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