



OKLAHOMA

State Board of Pharmacy

2920 N LINCOLN BLVD STE A • OKLAHOMA CITY OK 73105-4200
pharmacy@pharmacy.ok.gov • www.pharmacy.ok.gov
Dr. Marty Hendrick, Pharm.D., D.Ph, Executive Director
Phone: 405.521.3815 • Fax: 405.900.8365

November 21, 2022

For facilities located outside of the United States (US).

If you have a presence in the United States you may access our website to make payment by MasterCard, Visa, American Express or EFT from a savings or checking account:

<https://pay.apps.ok.gov/OSBP/payments>

If you do NOT have a US presence you will not be able to access our website.

Exception: If you are in Canada please contact the Board by phone at 405-522-3815 or by email at pharmacy@pharmacy.ok.gov for help processing a payment on our online store from Canada.

If you need to pay by federal ACH wire transfer, please send the email address of the person who will be making a federal ACH Wire transfer to the pharmacy email address.

The Board will email them the information to make payment. Our Oklahoma State Treasurer (OST) requires that the payment information be sent to the person who will be making the payment on behalf of the entity for security reasons.

OST requires us to send the information separately between two emails for security reasons.

If you have any questions or need assistance, please contact me.

If you haven't already, please mail / ship your completed application and documents

New applications to attention: Shakayla Gordon
Renewal applications attention: Marquise Robertson

OKLAHOMA STATE BOARD OF PHARMACY
2920 N LINCOLN BLVD STE A OKLAHOMA
CITY OK 73105-4212

A Constitutional Board Established in 1907



OKLAHOMA STATE BOARD OF PHARMACY

2920 N Lincoln Blvd, Suite A, Oklahoma City, OK 73105
Phone: (405) 521-3815 / Fax: (405) 900-8365
www.pharmacy.ok.gov / e-mail: pharmacy@pharmacy.ok.gov

2024-2025 NOTICE OF RENEWAL MEDICAL GAS DISTRIBUTOR LICENSE

FOR OSBP USE ONLY	
RECEIPT:	
DATE:	

DUE UPON RECEIPT
(PAYMENTS MADE ONLINE ONLY)
<https://pay.apps.ok.gov/OSBP/payments/>
Fee doubles 15 days after expiration
 EXPIRATION: _____
 LICENSE #: _____

A. Facility Name, DBA Name & Business Physical Address: _____ **Mailing Address:** _____

Describe your business practice at this location:	√Check all that apply	
		I supply medical gas on prescription orders issued to a patient.
		I distribute medical gas to medical gas suppliers or other entities licensed to use, administer, or distribute medical gas.
		Durable Medical Equipment (DME) / Devices issued to a patient (STOP! SEE MGD+ DME APPLICATION)
	Other. Please describe:	

B. Contact Information [notice of any deficiencies will be sent to the email given below for the *Facility Manager/Representative*]:

Designated Facility Manager/Representative: _____

Designated Facility Manager Phone: _____ E-Mail: _____

Facility Phone: _____ Facility Fax: _____ Facility hours: Mon-Fri _____

- C. Facility Registration / License Information:**
- If Transfilling occurs, FDA drug establishment registration is required.**
 - Copy of Facility's FDA Registration must be submitted with this application.
 - If this facility is NOT LOCATED IN OKLAHOMA, the following must be attached to this application:**
 - Copy of Valid Home State License (Must provide copy of actual license, online verification printout will not be accepted)
 - Copy of most recent Inspection Report (Conducted by Home State or FDA)
 - Current Description of Operations

D. Ownership	SOLE PROPRIETOR	CORPORATION	GOVERNMENT
	PARTNERSHIP	LLC	

Has there been any Change of Name, Ownership, or Location since your last application/renewal?
 ___ Yes ___ No *(If yes, a new application must be completed)*

For Change/Notification Requirements, please refer to Oklahoma Pharmacy Rules, Section 535:25-3-7

E. Disciplinary History:

Please answer each of the following questions YES (Y) or NO (N). For the purpose of the questions below, “applicant” means the Medical Gas Distributor listed in Section A above. All “YES” answers MUST be explained in detail in a separate addendum.

The addendum shall identify the person/entity to whom the “Yes” answer applies and shall include the jurisdiction and all other information requested. Failure to disclose any of the requested information may result in the denial of this application and/or other appropriate action.

The addendum form that shall be used to provide this information may be found at:

<https://ok.gov/pharmacy/Licensees & Applicants/Forms & Applications/Facilities/index.html>

1.	Since the last renewal or within the last 24 months, has the applicant or any of its owners or its designated representative or facility manager been convicted of any felony for conduct relating to prescription drugs, any felony for violation of 21 U.S.C. § 331 (i) or (k) or any felony for violation of 18 U.S.C. § 1365 relating to product tampering?	Y or N
2.	Since the last renewal or within the last 24 months, has the applicant or any of its owners or its designated representative or facility manager pled guilty or nolo contendere to or been found guilty of violating federal or state requirements for licensure that present a threat of serious adverse health consequences or death to humans?	Y or N
3.	Since the last renewal or within the last 24 months, has the applicant or any of its owners or its designated representative or facility manager pled guilty or nolo contendere to or been found guilty of violating any federal or state felony offense statutes or any federal or state misdemeanor offense statutes involving prescription drugs and/or controlled substances? Are any such charges or indictments pending?	Y or N
4.	Since the last renewal or within the last 24 months, has any federal (e.g., FDA, DEA) or state (e.g., OBND) regulatory or law enforcement agency found that the applicant or any of its owners or its designated representative or facility manager has violated any federal, state, or local laws or foreign laws? Is there any such action pending?	Y or N
5.	Since the last renewal or within the last 24 months, has suspension, revocation or any other sanction been imposed against a license currently or previously held by the applicant or any of its owners or its designated representative or facility manager for violating federal or state laws? Since the last renewal or within the last 24 months, has the applicant or any of its owners or its designated representative or facility manager surrendered a license?	Y or N
6.	Since the last renewal or within the last 24 months, has the applicant had any application for a license or permit refused or denied by any licensing authority?	Y or N
7.	Since the last renewal or within the last 24 months, has the applicant had a registration issued by a controlled substance authority revoked, suspended, surrendered, limited or restricted?	Y or N

I swear and affirm under penalty of perjury pursuant to Title 21 O.S. 491 and/or discipline by the Board of Pharmacy under the pharmacy laws and rules of the State of Oklahoma that all information I have supplied herein is true and complete.

THIS SIGNATURE MUST BE NOTARIZED:

State of _____)

County of _____)

Printed Name of Facility Manager/Representative

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

Signature of Facility Manager/Representative

Notary Public

THE FOLLOWING MUST BE SUBMITTED WITH THIS APPLICATION:

- \$200 Renewal Fee Receipt
- Copy of Home State License & Latest Inspection Report (Non-Resident)
- Current Description of Operations
- Copy of FDA Registration (if applicable)
- Charges & Convictions Addendum (if applicable)

PLEASE MAKE SURE THIS APPLICATION IS COMPLETE AND ALL ATTACHMENTS ARE PRESENT BEFORE SUBMISSION. VERIFY SIGNATURES AND NOTARIES. ANY DEFICIENCIES COULD RESULT IN THIS APPLICATION BEING RETURNED. SHOULD THIS HAPPEN, YOU WILL BE SUBJECT TO ANY LATE FEES/RESINSTATEMENT FEES ASSESSED. ANY CERTIFICATE NOT RENEWED IS SUBJECT TO CANCELLATION 30 DAYS AFTER EXPIRATION.