

Return Application  
 With Check Payable To:  
**NH Board of Pharmacy**  
 Annual Licensing Fee:  
**\$250**

**State of New Hampshire**  
**Board of Pharmacy**  
 57 Regional Drive  
 Concord, NH 03301-8518  
 Tel.: (603) 271-2350 Fax: (603) 271-2856  
 Website: www.nh.gov/pharmacy

Board Use Only (Do Not Write In This Box)  
 Check #: \_\_\_\_\_

**July 1, 2011 – June 30, 2012**  
**Registration Period**

**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 \_\_\_\_\_  
 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"/> LAAM <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: _____
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Applicant's Proposed Drug Activity: (To bona fide patients of clinic only) <input type="checkbox"/> Administer <input type="checkbox"/> Dispense "Take Home" Available: <input type="checkbox"/> Methadone <input type="checkbox"/> Buprenorphine	Drug Supply: <input type="checkbox"/> Bulk <input type="checkbox"/> Prepackaged* *Prepackaged By: _____ Location: _____
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**Name Of Owner(s): (Indicate Individual, Partners, Etc. - If Corporation, Show Title Of Officers) Attach Additional Sheet If Necessary**

Name _____	Address _____	Title _____
Name _____	Address _____	Title _____

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

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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Medical Director:**

Name _____	Address _____	Telephone Number _____
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**ALL QUESTIONS MUST BE ANSWERED AND COPIES ATTACHED OF DEA REGISTRATION & NH HEALTH & HUMAN SERVICES CERTIFIED DRUG TREATMENT PROVIDER CERTIFICATE**

**APPLICATION CONTINUED ON OTHER SIDE ↪**

**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.
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**Declaration And Signature By Clinic Representative:**

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, IN WRITING, OF ANY CHANGES IN THE INFORMATION CONTAINED IN THIS APPLICATION.**