New Mexico Board of Pharmacy
5200 Oakland NE Suite A
Albuquerque, NM 87113
Phone (505)222-9830
In-State Toll Free (800) 565-9102
www.rld.state.nm.us/pharmacy
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LIMITED DRUG PERMIT CLINIC APPLICATION

**APPLICATIONS AND FEES MUST ACCOMPANY EACH OTHER; OTHERWISE PROCESSING TIME WILL BE DELAYED.
RETAIN A COPY OF BOTH THE APPLICATION AND FORM OF PAYMENT FOR FUTURE REFERENCE.**
**Applications and fees must accompany each; otherwise processing time will be delayed.
Retain a copy of both the application and form of payment for future reference.
Mail early-5-10 days processing time once application is received**

INCLUDE A COPY OF THE CLINIC POLICY & PROCEDURES MANUAL TOGETHER WITH THE CLINIC FORMULARY AS DEFINED IN 16 NMAC 19.10.11(2) PROCEDURES MANUAL.

Mailing Address:
____
____
____
Fax Number: ________________
Email: ______________________

Location Address:
____
____
____
Phone Number: _________________

[ ] NEW [ ] CHANGE OF OWNERSHIP

FEE: $300.00 Biennial Renewal (Pay by check or money order)

[ ] Class A; [ ] Class B (1); [ ] Class B (2); [ ] Class B (3); [ ] Class C

Class A: Clinic drug permit for clinic where:
A: dangerous drugs are administered to patients of the clinic;
B: more than 12,500 dispensing units of dangerous drugs are dispensed or distributed annually.
Minimum space requirement: (240 sq. ft. room)

Class B: Clinic drugs permit for clinics where dangerous drugs are:
A: administered to patients of the clinic; and
B: dispensed or distributed to patients of the clinic. Class B drug permits shall Be issued by categories based on the number of dispensing units of dangerous Drugs to be dispensed or distributed annually, as follows:

I. CATEGORY 1 – up to 2,500 dispensing units;

II. CATEGORY 2 – from 2,501 – 7,500 dispensing units;

III. CATEGORY 3 – from 7,501 – 12,500 dispensing units.

Minimum space requirement: Categories 1 & 2 (48 sq. ft. room) and Category 3 (96 sq. ft. room)

Class C: Clinic drug permit for clinics where dangerous drugs are administered to patients of the clinic.
Minimum space requirement: An area adequate for the formulary.

I (we) hereby make application for Drugs Permit for dangerous drugs which will be administered and dispensed for and to patients on an out-patient basis, in accordance with the New Mexico Pharmacy Act, New Mexico Drug and Cosmetic Act; New Mexico Controlled Substances Act, and Board of Pharmacy Rules and Regulations.

I (we) hereby understand that the license expires December 31 of every other year, and that license or permit is not transferable. A separate license is necessary for each clinic location. This application must be received or postmarked by December 31. Please attach the late penalty of $75.00 if not postmarked by December 31.

Please circle letter beside appropriate category:

1. a. If an individual is owner, give name, address, and phone number;
   b. If a partnership is owner, give name, address and phone number of all partners (attach list)
   c. If a corporation or municipality, list name, address, phone number and title of all officers, (attach list);
   d. If county, city, state or church is owner, give name, address, phone number and title of all officers, (attach list);

NAME TITLE HOME ADDRESS CITY STATE ZIP

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Consultant Pharmacist: ________________________ License No: _____________ Cell Phone ___________

Pharmacy where employed: ____ License No:_______________

Clinic Federal DEA No: ____________________ NM Controlled Substance No: ________
Enter "pending" if applied for; or "N/A" for not applicable

2. I/We have not been arrested, investigated for, charged with, convicted of, sentenced for, entered a plea of nolo contendere, or entered into any other legal agreements for any criminal offence in any state, territory or possession of the United States or by the federal government.
Signature: ____

3. I/We have not had any disciplinary actions, nor have any pending actions against me/us, or to my knowledge been investigated by any professional licensing authority.
Signature: ____

4. Normal hours of operation:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Please explain any failure to sign questions two and/or three. Explain the circumstances, include a copy of the judgment, and attach to this application.

I/We hereby certify that the information given in this application is true and correct to the best of my (our) knowledge.

____ ___________________________
Signature – Owner or Officer **Date**

____
Print Name

____ ___________________________
Signature – Consultant Pharmacist **Date**

____
Print Name

____ ________________________
Facility Where Employed **Date**