

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 CLINIC RENEWAL 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**

MAIL EARLY – 5 TO 10 DAYS PROCESSING TIME ONCE APPLICATION IS RECEIVED

Name & Mailing Address:

Phone # _____
Fax No. _____
License Number _____

Location Address:

Phone # _____
Web Address _____
E-mail: _____

Check Appropriate Box Fee <Late Fee> (Submit check or money order)

- Class A, B, C (Biennial) \$300 <\$75.00>
- Animal Control (Biennial) \$100 <\$25.00>
- EMS Primary Location (Annual) \$50 <\$12.50>
- Each EMS In-Use Location (Annual) \$25 <\$6.25>
- Home Health Care (Annual) \$75 <\$18.75>

I/we hereby make applications for a Drug Permit for dangerous drugs, which will be administered and dispensed for and to patients on outpatient basis, in accordance with the New Mexico Pharmacy Act, New Mexico Drug and Cosmetic Act; New Mexico Controlled Substance Act, and Board of Pharmacy Rules & Regulations.

I/we hereby understand the license expires December 31st of every other year, and the license or permit is not transferable. A separate license is necessary for each clinic location. This application must be received or postmarked December 31. If not postmarked by December 31, attach late penalty.

*I/we have not since the time of our last renewal, been arrested, investigated for, charged with, convicted of, sentenced, entered a plea of nolo 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 _____

*I/we have not since the time of our last renewal, had any disciplinary actions, or has any professional licensing authority investigated any pending actions against us.**
Signature _____

***Please explain any failure to sign the statements above. Explain the circumstances, include a copy of the judgment, and attach to this application.**

I (we) certify under penalty of perjury that the information given in this application is true and accurate to the best of my (our) knowledge.

Signature – Owner or Officer

Print Name of Owner or Officer

Date

Signature – Consultant Pharmacist

(Print Name of Pharmacist & Lic Number)

Date

Pharmacy Where Employed

Phone Number

Consultant pharmacist (Class A, B, C only) must complete self-assessment form, send self-assessment form with renewal and retain a copy of self-assessment form in clinic for future inspections.