DISPENSING PERMIT APPLICATION

09/2017

MARYLAND BOARD OF PHYSICIANS

P.O. Box 37217; Baltimore, Maryland 21297
410-764-5977 or 1-800-492-6836, ext. 5977

APPLICATION FOR PHYSICIAN'S PERMIT TO DISPENSE PRESCRIPTION DRUGS

INSTRUCTIONS AND IMPORTANT INFORMATION

For Bank Use Only

Date: _____/_____/_____
Check Number: _____
Amt. Paid: _____
Name Code: _____
AppID: 32

Fee: $1,050.00

1. Review the Frequently Asked Questions (FAQs) on the Board of Physicians' (the Board's) Website to determine whether you need a dispensing permit.
2. Complete Items 1 through 4 below.
3. Complete Item 5, if applicable.
4. For Item 6 on the next page, read and initial each letter after the certification.
5. Mail the completed and signed form with a check or money order for $1,050.00, payable to the Maryland Board of Physicians, to the above address.
6. If prescriptions will be dispensed in more than one location, you must keep a copy of the dispensing permit at each location.
7. Permits are valid for five (5) years from the date of issue.
8. Applicants for permit renewal must complete required continuing education credits but do not need to submit the documentation to the Board with this application. See Item 6E on Page 2.

Application for (check one): _____ Initial Permit _____ Renewal

If renewal, Permit # _____ Expiration Date: _____ /_____ / _____

1. Physician License Number: _____ E-mail Address: _____

2. Physician Name: _____
Last First Middle/Maiden

3. "In the public interest" as defined in Health Occupations Article (H.O.A.) §12-102(a)(2) means "the dispensing of drugs or devices by a licensed [physician] to a patient when a pharmacy is not conveniently available to the patient." Please explain why your permit would be in the public interest.

_____

_____

_____

4. Primary Practice address where prescription drugs will be dispensed.

Facility Name:	Street Address:
City: State: Zip Code:	Telephone Number:

5. Additional Practice address(es) where drugs will be dispensed.

_____ _____
Facility Name and Street Address City State Zip Code Telephone #

_____ _____
Facility Name and Street Address City State Zip Code Telephone #

_____ _____
Facility Name and Street Address City State Zip Code Telephone #

_____ _____
Facility Name and Street Address City State Zip Code Telephone #

6. Please read and initial the space on the left of each lettered paragraph as acknowledgment.

I HEREBY CERTIFY THAT:

Initials

_____ A. I have read and understood the FAQs for physicians who are dispensing drugs.

_____ B. I am thoroughly familiar with the statutes and regulations which govern physician dispensing of prescription drugs, including, but not limited to, H.O.A. §§12-102, 12-505, and 12-604, and Code of Maryland Regulations (COMAR) 10.13.01, 10.19.03.04, 10.19.03.05, and 10.19.03.07.

_____ C. I will follow all requirements set forth in Maryland and Federal law regarding dispensing, labeling, record keeping, storing of drugs, and patient notifications in order to receive and maintain a permit to dispense prescription drugs. Failure to comply with Federal or State laws and regulations may be considered a violation of H.O.A. §14-404(a)(28).

_____ D. I will annually report to the Board whether I have personally prepared and dispensed prescription drugs within the previous year. I understand that I will be contacted by the Board either by e-mail or by letter around November 1 to provide this information to the Board, and I will provide the requested information in an expedited manner. I further understand that my failure to respond to Board inquiries in an expedited manner regarding my dispensing of prescription drugs may be determined to be a violation of the Maryland Medical Practice Act and the Secretary of Health's regulations. See H.O.A. §12-102.

_____ E. (Initial only if you are seeking a renewal permit. Skip this question if you are applying for an initial permit.) With the exception below, I personally completed ten continuing education (CE) credits over a 5-year period relating to the preparing and dispensing of prescription drugs, offered by the Accreditation Council for Pharmacy Education (ACPE) or as approved by the Secretary. The required CE credits are phased in as follows:

1. For permits that expire in 2017, the physician shall complete eight continuing education credits;
2. For permits that expire in or after 2018, the physician shall complete ten continuing education credits.

I understand that the Board conducts random CE audits. If I am contacted by the Board, I will cooperate with the Board by submitting documentation of my CE credits in a timely manner.

_____ F. I understand that I may not have a substantial financial interest in a pharmacy in accordance with H.O.A. §12-102(c)(2)(ii)(3).

_____ G. I understand that I may not direct patients to a single pharmacist or pharmacy in accordance with H.O.A. §12-102(c)(2)(ii)(4)(F).

_____ H. I understand that I must be physically present and personally must perform the final check of each prescription dispensed as required by H.O.A. §12-102(a)(3).

_____ I. I will ensure that signs are posted at each dispensing location in accordance with COMAR 10.13.01.04O.

_____ J. I will allow the Office of Controlled Substances Administration to enter and inspect the dispensing office at all reasonable hours and in accordance with H.O.A. §12-102.1 and COMAR 10.13.01.05B.

I hereby affirm that I have personally completed this application and that the information I have given is true and accurate to the best of my knowledge.

_____ _____

Physician's Name in Print Date

_____

Physician's Signature