New Mexico Regulation and Licensing Department

BOARDS AND COMMISSIONS DIVISION

Board of Pharmacy

5500 San Antonio Drive NE, Suite C ▪ Albuquerque, New Mexico 87109

(505) 222-9830 ▪ (800) 565-9102

http://www.rld.state.nm.us/boards/pharmacy.aspx

Emergency Medical Service Application

Check a box: ❑ NEW ❑ Change of Ownership ❑ Adding an "In Use" location

Name & Mailing Address

_____

_____

_____

Telephone Number: _____

Location Address: (If different than mailing)

_____

_____

_____

Fax Number: _____

Contact Person Name and Title: _____ Telephone Number _____

FEE: Make check or money order payable to New Mexico Board of Pharmacy.

❑**$50** for each "Principal Place of Business"

❑**$25** for each "In Use" Location, **must** have a "Principal Place of Business" to add an "In Use"

"Principle Place of Business" refers to any sites that are part of the EMS's operations, including its headquarters, stations, vehicle bays, docks, or hangars where dangerous drugs and/or controlled substances are stored**,** but does not include dangerous drugs or controlled substances "in use".

"In Use" means when dangerous drugs and controlled substances are removed from the principle place of business' inventory and placed in jump kits or mobile units for emergency use.

EMS services using controlled substances must acquire a New Mexico Facility Controlled Substance Registration and a Drug Enforcement Administration Registration for each principle place of business that receives/stores/distributes controlled substances.
List each Principle Place of Business location address: (**attach list**)
List each In Use Location address: (**attach list**)

I, (we) the undersigned, hereby apply for a license to operate and Emergency Medical Service under the Pharmacy Laws of the State of New Mexico and present the following statements in support of the privilege to be granted a license and represent that if such license is granted, such place will be conducted in full compliance with existing Pharmacy laws, and rules and regulations of the Board of Pharmacy.

I (we) understand that license is due December 31 of every year and that license or permit is not transferable, and furthermore that a separate license is necessary for each location of doing business.

Please make sure that #1-6 are all answered and/or included with application before submittal

1. **EMS Clinic Policy & Procedure Manual must be submitted with all new application.**
   NOTE: New applications received in the Board office less than 14 days prior to the next scheduled Board meeting will not be processed at that board meeting and will have to wait till the next one.
2. **Circle letter beside appropriate category. (If b, c or d please attach list on a separate piece of paper)**
   a) If an individual is owner, give name, address and phone number;
   b) If a partnership is owner, give name, address and phone numbers 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);**
3. **Consultant Pharmacist Name (Print): _____ License #: _____**
4. **Supervising Staff Physician (Print): _____ License #: _____**
5. **Supervising EMT Name (Print): _____**
6. **Certified EMT's (Attach List): _____**

I (we) have not been arrested, investigated, charged, convicted, 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 any disciplinary actions, or have any pending actions against me/us, or to my knowledge been investigated by any professional licensing authority. *****
Signature_____

*****If the above statements are not true, 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.

_____	_____	_____
Administrator Signature	**Administrator printed name**	**Date**
_____	_____	_____
Consultant Pharmacist Signature	**Consultant Pharmacist printed name**	**Date**