State of Florida
Department of Business and Professional Regulation
Drugs, Devices, and Cosmetics Program

Application for Exemption Registration
Form No.: DBPR – DDC – 227

If you have any questions or need assistance in completing this application, please contact the Department of Business and Professional Regulation, Drugs, Devices, and Cosmetics Program, at 850.717.1800.

Section I – Application Type

CHECK ONE OF THE APPLICATION TYPES
☐ New Exemption [3311/1020] ☐ Exemption Renewal [3311/2020] – Current Exemption Number: _______________ ☐ Exemption Amendment [3311/2020] – Current Exemption Number: _______________

Section II – Exemption Qualification Criteria

CHECK THE APPLICABLE QUALIFICATION CRITERIA
☐ State, federal, or local governmental officer or employee ☐ Qualified person using prescription drugs for lawful ☐ research, ☐ teaching or ☐ testing (check each that applies); not for resale.

Section III – Applicant Information

ORGANIZATON / BUSINESS INFORMATION		
1. Name of Organization / Business:		
2. Mailing Address (Street and Number):		
City:	**State:**	**Zip Code:**
3. Physical Address (Street and Number) - Where the drugs/gases will be received and related records stored):		
City:	**State:**	**Zip Code:**

Section IV – Qualified Person Information

QUALIFIED PERSON USING PRESCRIPTION DRUGS

Name:

EDUCATIONAL DATA

SELECT HIGHEST GRADE COMPLETED				
			High School	☐ 1 ☐ 2 ☐ 3 ☐ 4
			College	☐ 1 ☐ 2 ☐ 3 ☐ 4
			Graduate School	☐ 1 ☐ 2 ☐ 3 ☐ 4

Name of College or University	Location (City, State)	Dates Attended (MM/YY to MM/YY)	Did you Graduate	Major/Minor or Area of Study
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

RELATED TRAINING / COURSE WORK: (VOCATIONAL, TRADE, GOVERNMENTAL, BUSINESS, ARMED FORCES, ETC.)

Name of School	Location (City, State)	Dates Attended (MM/YY to MM/YY)	Training Completed	Area of Training or Study
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

EXPERIENCE

Please summarize the qualified person's experience in working with (or using) prescription drugs for the purpose in which the prescription drugs are being used. For example, if the purpose for use of the prescription drugs is research, teaching, and testing, the summary and description should set out the qualified person's experience in using the prescription drugs research, teaching, and testing that qualifies the person for the exemption being sought.

Summary and Description of Experience:

Section V –Purchasing Information

PURCHASING INDIVIDUAL INFORMATION
1. Name in which purchases will be made:
2. Does this person have a DEA Registration Number? ☐ Yes ☐ No If yes, provide: Registration No: ______________________ Expiration Date: _____________________
PURPOSE FOR USE
3. Explain the conditions of the lawful research, teaching or testing purposes. Use additional pages if necessary.

4. Name of Florida Licensed Supplier of the Prescription Drugs or Gases

Name	Florida License Number

5. List all the prescription drug(s) or gases required for the activity. Use additional page if necessary.

Prescription Drug/Gas Name	Anticipated Quantity Each Purchase	Frequency

Section VI – Application Contact

PERSON TO CONTACT FOR QUESTIONS ABOUT APPLICATION		
1. Name of Contact Person regarding questions for this application:		
Address (Street and Number):		Telephone Number:
City:	State:	Zip Code:
E-Mail Address:		Fax Number (Optional):

Section VII - Affidavit

AFFIDAVIT

Each application for a license or renewal of a license issued by the Department of Business and Professional Regulation shall be signed under oath or affirmation by the applicant, or owner or chief executive of the applicant without the need for witnesses unless otherwise required by law.

I hereby certify the following:

1. The drugs/gases will be secured and access to the drugs/gases will be restricted to authorized individuals.
2. The drugs are not for resale.
3. I am the individual who will be responsible for prescription drugs received under any exemption letter pursuant to this application.
4. I am empowered to execute this application as required by section 559.79, FS.
5. I understand that my signature on this application has the same legal effect as if made under oath.
6. All information contained on this application is true and correct. **I understand that falsification of any information on this application may result in administrative action, including a fine, suspension or revocation of the exemption and potential criminal penalties.**

Signature:	Date:
Print Name:	

Submit your application, any additional pages, and all required supporting documentation to:

Drugs, Devices, and Cosmetics Program
2601 Blair Stone Road
Tallahassee, FL 32399-1047
850-717-1800