

MEMORANDUM

TO: MISSOURI LICENSED VETERINARIAN-IN-CHARGE

FROM: DANA K. FENNEWALD, EXECUTIVE DIRECTOR

SUBJECT: PERMIT APPLICATION AND VETERINARY FACILITY SELF-INSPECTION FORM

Please find enclosed a Permit Application and Veterinary Facility Self-Inspection form. This application will need to be completed and returned to this office along with the appropriate fee. Please indicate on the top of this form whether this application is a "change" (i.e. existing veterinary practice with a change of ownership, name, function or location) or an "initial" (i.e. brand new veterinary practice that just opened and was never licensed as a veterinary practice by anyone previously).

If this practice will be owned by a corporation (professional or other), L.L.C., partnership or other business organization then the corporation, partnership or other business organization must be named in the section titled "Veterinary Practice Owner". Also, if a corporation, partnership or other business organization owns the veterinary practice, **you must submit a file stamped copy of the articles of incorporation, partnership agreement or business organization documents. The articles of incorporation or business organization documents must clearly state that the licensed veterinarian is not subject to the direction of anyone not licensed to practice veterinary medicine in Missouri in making veterinary medical decisions or judgments.**

Upon receipt of the above information, we will begin processing your application. If you should have any questions concerning this matter, please do not hesitate to contact this office.



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
PERMIT APPLICATION AND
VETERINARY FACILITY SELF-INSPECTION

- INITIAL APPLICATION (\$100)
- CHANGE IN OWNERSHIP (\$100)
- CHANGE IN PHYSICAL LOCATION (\$100)
- CHANGE IN FUNCTION (\$25)
- CHANGE IN FACILITY NAME (\$25)
- IF CHANGE, PROVIDE PREVIOUS PERMIT NO. _____

FOR OFFICE USE ONLY	
PERMIT NO.	DATE ISSUED

INSTRUCTIONS

All applicants must complete Sections I, II and X. Complete only those other sections III-IX relevant to your situation. Enclose the appropriate fee and return this application to: Missouri Veterinary Medical Board, P.O.Box 633, Jefferson City, MO 65102. Telephone 573/751-0031. If additional space is needed, use back of form.

If this facility will be owned by a corporation (professional or other), L.L.C., partnership or other business organization then the corporation, partnership or other business organization must be named in the section titled "Veterinary Practice Owner". Also, if a corporation, partnership or other business organization owns the veterinary facility/practice, you must submit a file stamped copy of the articles of incorporation, partnership agreement or business organization documents. The articles of incorporation or business organization documents must clearly state that the licensed veterinarian is not subject to the direction of anyone not licensed to practice veterinary medicine in Missouri in making veterinary medical decisions or judgments.

I. IDENTIFYING INFORMATION (ALL LICENSED VETERINARIANS AND VETERINARY TECHNICIANS EMPLOYED AT THE FACILITY MUST BE LISTED BELOW. IF ADDITIONAL SPACE IS NEEDED, ATTACH A SEPARATE SHEET.)

FACILITY NAME	TELEPHONE NUMBER
FACILITY ADDRESS (STREET, CITY, COUNTY, STATE, ZIP CODE)	EIN NUMBER
VETERINARY PRACTICE OWNER (IF VETERINARIAN OWNED, LIST VETERINARIANS NAME/IF CORPORATION, NAME CORPORATION)	LICENSE NUMBER
VETERINARIAN IN CHARGE	LICENSE NUMBER
LICENSED VETERINARIAN	LICENSE NUMBER
LICENSED VETERINARIAN	LICENSE NUMBER
LICENSED VETERINARIAN	LICENSE NUMBER
VETERINARY TECHNICIAN	LICENSE NUMBER
VETERINARY TECHNICIAN	LICENSE NUMBER

TYPE OF PRACTICE (CHECK ALL THAT APPLY. REFER TO §340.200 (29), RSMo)

<input type="checkbox"/> VETERINARY HOSPITAL OR CLINIC	<input type="checkbox"/> CENTRAL HOSPITAL	<input type="checkbox"/> SATELLITE OUT-PATIENT CLINIC	<input type="checkbox"/> LARGE ANIMAL MOBILE CLINIC	<input type="checkbox"/> EMERGENCY CLINIC	<input type="checkbox"/> SPECIALTY FACILITIES
		<input type="checkbox"/> MOBILE SMALL ANIMAL CLINIC			

II. ALL VETERINARY FACILITIES (MUST BE COMPLETED FOR ALL PERMIT APPLICATIONS)

	YES	NO
1. Library of textbooks or current journals?	<input type="checkbox"/>	<input type="checkbox"/>
2. Proper storage and environmental control for all medicines and biologics based on the manufacturer's recommendations?	<input type="checkbox"/>	<input type="checkbox"/>
3. Current licenses conspicuously displayed?	<input type="checkbox"/>	<input type="checkbox"/>
4. Properly maintained records as required in 20 CSR 2270-4.041?	<input type="checkbox"/>	<input type="checkbox"/>

III. VETERINARY HOSPITALS OR CLINICS

	YES	NO
5. Legible sign?	<input type="checkbox"/>	<input type="checkbox"/>
6. Facility clean and in good repair?	<input type="checkbox"/>	<input type="checkbox"/>
7. Grounds clean and well maintained?	<input type="checkbox"/>	<input type="checkbox"/>
8. Licenses/registrations displayed?	<input type="checkbox"/>	<input type="checkbox"/>
9. Licenses/registrations current?	<input type="checkbox"/>	<input type="checkbox"/>
10. Facility requirements:		
a. adequate lighting?	<input type="checkbox"/>	<input type="checkbox"/>
b. hot and cold running water?	<input type="checkbox"/>	<input type="checkbox"/>
c. adequate ventilation?	<input type="checkbox"/>	<input type="checkbox"/>
d. adequate fire precautions?	<input type="checkbox"/>	<input type="checkbox"/>
e. method for disposal of waste materials?	<input type="checkbox"/>	<input type="checkbox"/>
f. method for disposal of deceased animals?	<input type="checkbox"/>	<input type="checkbox"/>
g. sterilization or sanitation of equipment?	<input type="checkbox"/>	<input type="checkbox"/>
h. adequate diagnostic radiological services? (in-house or through other facilities)	<input type="checkbox"/>	<input type="checkbox"/>
i. laboratory and pharmaceutical facilities? (in-house or through commercial facilities)	<input type="checkbox"/>	<input type="checkbox"/>

III. VETERINARY HOSPITALS OR CLINICS

- | | YES | NO |
|--|--------------------------|--------------------------|
| 11. Facility have reception/office area? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Facility have separate examination room? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Facility have a designated surgery area? | <input type="checkbox"/> | <input type="checkbox"/> |

HOUSING AREAS

- | | | |
|---|--------------------------|--------------------------|
| 14. Animal identification system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Separate compartments of adequate size? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Accommodations for separation of contagious and non-contagious animals? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Exercise areas or documentation of walking in lieu of exercise areas? | <input type="checkbox"/> | <input type="checkbox"/> |

EQUIPMENT

- | | | |
|--|--------------------------|--------------------------|
| 18. Anesthetic equipment appropriate for level of surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Oxygen equipment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Surgical packs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Examination and treatment areas equipped with: | | |
| a. waste receptacles with liners? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. disposable towels? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. table with impervious surface? | <input type="checkbox"/> | <input type="checkbox"/> |

IV. CENTRAL HOSPITALS

(To be completed only if facility meets criteria of Section 340.200(29)(c)) (Section III must also be completed)

- | | YES | NO |
|--|--------------------------|--------------------------|
| 22. On-premises 24-hour nursing care? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Intensive care unit? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Laboratory facilities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Radiological services? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Cardiac monitoring? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Positive ventilation gas anesthesia? | <input type="checkbox"/> | <input type="checkbox"/> |

V. SATELLITE OUT-PATIENT CLINIC

To be completed only if facility meets criteria of Section 340.200(29)(d))

28. Name and permit number of permitted full-service veterinary hospital or clinic or the name of the permitted central hospital that own or is associated with the satellite out-patient clinic.

_____ FACILITY NAME (PLEASE PRINT)

_____ PERMIT NUMBER

- | | YES | NO |
|--|--------------------------|--------------------------|
| 29. Hot and cold running water? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. 110 volt power source for diagnostic equipment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Collection tank for disposal of waste material? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Adequate lighting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Table and counter tops which can be cleaned and disinfected? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Floor coverings which can be cleaned and disinfected? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Adequate heating, cooling and ventilation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Separate compartments to hold animals? | <input type="checkbox"/> | <input type="checkbox"/> |

VI. MOBILE SMALL ANIMAL CLINIC

(To be completed only if facility meets criteria of Section 340.200(29)(d))

37. Name and permit number of permitted full-service veterinary hospital or clinic or the name of the permitted central hospital that owns or is associated with the mobile small animal clinic.

_____ FACILITY NAME (PLEASE PRINT)

_____ PERMIT NUMBER

- | | YES | NO |
|--|--------------------------|--------------------------|
| 38. Method for disposal of waste materials? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Method for disposal of deceased animals? | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Capability to sterilize or sanitize equipment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Surgical packs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Separate compartments to transport animals? | <input type="checkbox"/> | <input type="checkbox"/> |

VII. LARGE ANIMAL MOBILE CLINIC

(To be completed only if facility meets criteria of Section 340.200(29)(e))

	YES	NO
43. For sterile surgery, the facility has:		
a. sterile surgical instruments?	<input type="checkbox"/>	<input type="checkbox"/>
b. suturing materials?	<input type="checkbox"/>	<input type="checkbox"/>
c. syringes and needles?	<input type="checkbox"/>	<input type="checkbox"/>
44. A means of cold sterilization?	<input type="checkbox"/>	<input type="checkbox"/>
45. Protective clothing and rubber or disposable boots?	<input type="checkbox"/>	<input type="checkbox"/>
46. Current and properly stored pharmaceuticals and biologicals?	<input type="checkbox"/>	<input type="checkbox"/>
47. OB sleeves?	<input type="checkbox"/>	<input type="checkbox"/>

VIII. EMERGENCY CLINICS

**(To be completed only if facility meets criteria of Section 340.200(29)(f))
(Section III must also be completed)**

	YES	NO
48. Licensed veterinarian on premises at all times during posted hours of operation?	<input type="checkbox"/>	<input type="checkbox"/>
49. Advertisements state:		
a. licensed veterinarian on premises during posted hours of operation?	<input type="checkbox"/>	<input type="checkbox"/>
b. the hours facility will provide emergency service?	<input type="checkbox"/>	<input type="checkbox"/>
c. the address and telephone number of the facility?	<input type="checkbox"/>	<input type="checkbox"/>
50. Adequate diagnostic radiological equipment?	<input type="checkbox"/>	<input type="checkbox"/>
51. Adequate laboratory equipment?	<input type="checkbox"/>	<input type="checkbox"/>
52. Diagnostic cardiac monitoring equipment?	<input type="checkbox"/>	<input type="checkbox"/>

IX. SPECIALTY CLINICS

Specialty clinics must meet the criteria of Section 340.200(29)(b). Services must be limited to procedures such as training, rehabilitation, and other modalities not requiring facilities otherwise permitted by the board. A description of the procedures to be utilized and the design of the facility must be submitted in writing. The practice of the facility is strictly limited to that approved by the Board.

X. MILITARY

- 1. Have you ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable? Yes No
- 2. If yes, would you like to receive information and assistance regarding veterans benefits and services? Yes No
- 3. If yes, may the agency share your contact information with the Missouri Veterans Commission to provide such information? Yes No

General information may also be found at the Missouri Veterans Commission's website.

XI. AFFIDAVIT (ALL APPLICANTS MUST COMPLETE)

Pursuant to Section 324.010 RSMo:

CHECK THIS BOX ONLY IF IN ALL OF THE LAST THREE (3) YEARS: YOU WERE NOT A MISSOURI RESIDENT, YOU DID NOT HAVE ANY MISSOURI INCOME, AND YOU ARE NOT SUBJECT TO ANY TYPE OF MISSOURI INCOME TAX.

False statements are subject to criminal penalties and/or license discipline.

If you have any questions regarding taxes contact the Department of Revenue at 573-751-7200 or e-mail income@dor.mo.gov.

I hereby affirm that the information given above is true, correct and complete to the best of my knowledge and belief. I am aware that any person who knowingly submits false information, information intended to mislead the board, or omits a material fact on the application shall be subject to penalties provided for by the laws of Missouri, in addition to any actions which the board may take pursuant to the provisions of Chapter 340, RSMo.

I further authorize the release of any information needed by the Missouri Veterinary Medical Board to determine my facility's eligibility for a permit.

SIGNATURE	DATE
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IMPORTANT NOTICE – IMMEDIATE ACTION REQUIRED

Missouri state law requires that a business licensed by the state that engages in retail sales provide a no tax due letter from the **Department of Revenue** at the time of licensing. Section 114.083.4 RSMo. (Cum Supp 2007) states:

In addition to the provisions of subsection 2 of this section, beginning January 1, 2009, **the possession of a statement from the department of revenue stating no tax is due under sections 143.191 to 143.265, RSMo, or sections 144.010 to 144.510 shall also be a prerequisite to the issuance or renewal of any city or county occupation license or any state license required for conducting any business where goods are sold at retail.** The statement of no tax due shall be dated no longer than ninety days before the date of submission for application or renewal of the city or county license.

You may obtain a tax clearance letter by visiting <http://dor.mo.gov/tax/business/sales/notaxdue/index.htm>, e-mailing <mailto:taxclearance@dor.mo.gov>, or calling the Department of Revenue at (573) 751-9268.

Compliance Statement

- A tax clearance letter issued within the last 90 days is attached to this statement.
- This entity does not engage in the sale of goods at retail.

WARNING: Statements made on this form are subject to audit. A false statement on this form subjects the license to discipline. Any person who makes a false statement on this form, and the business for which the false statement is made, are subject to criminal penalties for misleading a public servant. § 575.060 RSMo.

Name of entity: _____ License No. _____

Signature: _____ Title: _____
(owner, president, partner)

Print Name: _____