

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

Request for Letter of Exemption
Form No.: DBPR – DDC – 227

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

Section I – Request Type

CHECK ONE OF THE REQUEST TYPES
<input type="checkbox"/> New Letter of Exemption [3311/1020]
<input type="checkbox"/> Letter of Exemption Amendment [3311/9007] – Current Letter of Exemption Registration Number: _____

Section II – Qualification Criteria

CHECK THE APPLICABLE QUALIFICATION CRITERIA
<input type="checkbox"/> State, federal, or local governmental officer or employee
<input type="checkbox"/> Qualified person using prescription drugs for lawful <input type="checkbox"/> research, <input type="checkbox"/> teaching or <input type="checkbox"/> testing (check each that applies); not for resale.

Section III – Requester Information

REQUESTER INFORMATION		
1. Requester's Name (Last, First, Middle)		
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 – Business Entity Information

BUSINESS ENTITY AND PHYSICAL LOCATION ADDRESS		
1. Business Entity Name (Name of Company individual works for):		
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 V – Education/Related Training

EDUCATIONAL DATA				
SELECT HIGHEST GRADE COMPLETED			High School College Graduate School	<input type="checkbox"/> 1 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 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
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> 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
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> 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:

Submit your request, 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