

APPLICATION FOR REGISTRATION Under the Controlled Substances Act

INSTRUCTIONS

Save time - apply on-line at www.deadiversion.usdoj.gov

- 1. To apply by mail complete this application. Keep a copy for your records. 2. Mail this form to the address provided in Section 7 or use enclosed envelope. 3. The "MAIL-TO ADDRESS" can be different than your "PLACE OF BUSINESS" address. 4. If you have any questions call 800-882-9539 prior to submitting your application.

IMPORTANT: DO NOT SEND THIS APPLICATION AND APPLY ON-LINE.

DEA OFFICIAL USE :

Grid for DEA Official Use

Do you have other DEA registration numbers?

NO YES checkboxes

MAIL-TO ADDRESS

Please print mailing address changes to the right of the address in this box.

FEE FOR THREE (3) YEARS IS \$731 FEE IS NON-REFUNDABLE

SECTION 1 APPLICANT IDENTIFICATION

Individual Registration Business Registration checkboxes

Name 1 (Last Name of individual -OR- Business or Facility Name)

Name 1 input field

Name 2 (First Name and Middle Name of individual - OR- Continuation of business name)

Name 2 input field

PLACE OF BUSINESS Street Address Line 1

Street Address Line 1 input field

PLACE OF BUSINESS Address Line 2

Address Line 2 input field

City

City input field

State

Zip Code

State and Zip Code input fields

Business Phone Number

Business Phone Number input field

Point of Contact

Point of Contact input field

Cell Phone Number

Cell Phone Number input field

Email Address

Email Address input field

DEBT COLLECTION INFORMATION

Social Security Number (if registration is for individual)

Social Security Number input field

Provide SSN or TIN. See additional information note #3 on page 4.

Tax Identification Number (if registration is for business)

Tax Identification Number input field

Mandatory pursuant to Debt Collection Improvements Act

FOR Practitioner or MLP ONLY:

Professional Degree: select from list only

Professional Degree input field

Professional School:

Professional School input field

Year of Graduation:

Year of Graduation input field

National Provider Identification:

National Provider Identification input field

Date of Birth (MM-DD-YYYY):

Date of Birth input field

SECTION 2 BUSINESS ACTIVITY

Check one business activity box only

- Central Fill Pharmacy, Retail Pharmacy, Nursing Home, Automated Dispensing System (ADS), Practitioner (DDS, DMD, DO, DPM, DVM, or MD), Practitioner Military (DDS, DMD, DO, DPM, DVM, or MD), Mid-level Practitioner (MLP) (DOM, HMD, MP, ND, NP, OD, PA, or RPH), Euthanasia Technician, Ambulance Service, Animal Shelter, Hospital/Clinic, Teaching Institution

FOR Automated Dispensing System (ADS) ONLY:

DEA Registration # of Retail Pharmacy for this ADS

DEA Registration # input field

An ADS is automatically fee-exempt. Skip Section 6 and Section 7 on page 2. You must attach a notarized affidavit.

SECTION 3 DRUG SCHEDULES

Check all that apply

- Schedule 2 Narcotic, Schedule 2 Non-Narcotic (2N), Schedule 3 Narcotic, Schedule 3 Non-Narcotic (3N), Schedule 4, Schedule 5

Check this box if you require official order forms - for purchase of schedule 2 controlled substances.

SECTION 4

You **MUST** be currently authorized to prescribe, distribute, dispense, conduct research, or otherwise handle the controlled substances in the schedules for which you are applying under the laws of the **state** or jurisdiction in which you are operating or propose to operate.

STATE LICENSE(S)

MANDATORY

State License Number

[Grid for State License Number]

Expiration Date / / MM - DD - YYYY

Be sure to include both state license numbers

State Controlled Substance License Number

[Grid for State Controlled Substance License Number]

Expiration Date / / MM - DD - YYYY

Which state or jurisdiction issued these licenses? _____

SECTION 5 LIABILITY (All questions in this section must be answered.)

YES NO

1. Has the applicant ever been **convicted of a crime** in connection with controlled substances(s) under state or federal law?

YES NO

Date(s) of incident MM-DD-YYYY: _____

YES NO

2. Has the applicant ever been excluded or directed to be excluded from participation in a Medicare or state health care program, or is any such action pending?

YES NO

Date(s) of incident MM-DD-YYYY: _____

YES NO

3. Has the applicant ever surrendered (for cause) or had a **federal** controlled substance registration revoked, suspended, restricted, or denied or is any such action pending?

YES NO

Date(s) of incident MM-DD-YYYY: _____

YES NO

4. Has the applicant ever surrendered (for cause) or had a **state** professional license or controlled substance registration revoked, suspended, denied, restricted, or placed on probation, or is any such action pending?

YES NO

Date(s) of incident MM-DD-YYYY: _____

YES NO

5. If the applicant is a corporation (other than a corporation whose stock is owned and traded by the public), association, partnership, or pharmacy has any officer, partner, stockholder, or proprietor been convicted of a crime in connection with controlled substance(s) under state or federal law, or ever surrendered, for cause, or had a federal controlled substance registration revoked, suspended, restricted, denied, or ever had a state professional license or controlled substance registration revoked, suspended, denied, restricted or placed on probation, or is any such action pending?

YES NO

Date(s) of incident MM-DD-YYYY: _____ Note: If question 5 does not apply to you, be sure to mark 'NO'.

EXPLANATION OF "YES" ANSWERS

Applicants who have answered "YES" to any question above must provide an explanation.

Liability question # _____ Location(s) of incident: _____

Nature of incident (if necessary, attach a separate sheet and return with application):

Disposition of incident:

SECTION 6 EXEMPTION FROM APPLICATION FEE

Check this box if the applicant is a federal, state, or local government official or institution. Does not apply to contractor-operated institutions.

Business or Facility Name of Fee Exempt Institution. **Be sure to enter the address of this exempt institution in Section 1.**

[Grid for Business or Facility Name]

The undersigned hereby certifies that the applicant named hereon is a federal, state or local government official or institution, and is exempt from payment of the application fee.

FEE EXEMPT CERTIFIER

Signature of certifying official (other than applicant)

Date

Provide the name and phone number of the certifying official

Print or type name and title of certifying official

Telephone No. (required for verification)

SECTION 7

METHOD OF PAYMENT

Check one form of payment only

Check Make check payable to: **Drug Enforcement Administration** See page 4 of instructions for important information.

American Express Discover Master Card Visa

Credit Card Number

[Grid for Credit Card Number]

Expiration Date

[Grid for Expiration Date]

Mail this form with payment to:

DEA Headquarters
ATTN: Registration Section/ODR
PO Box 2639
Springfield, VA 22152-2639

FEE IS NON-REFUNDABLE

Sign if paying by credit card

Signature of Card Holder

Printed Name of Card Holder

SECTION 8

I certify that the foregoing information furnished on this application is true and correct.

APPLICANT'S SIGNATURE

Signature of applicant (sign in ink)

Date

Sign in ink

Print or type name and title of applicant

WARNING: 21 USC 843(d), states that any person who knowingly or intentionally furnishes false or fraudulent information in the application is subject to a term of imprisonment of not more than 4 years, and a fine under Title 18 of not more than \$250,000, or both.

SECTION 4

STATE LICENSE

You **MUST** be currently authorized to prescribe, distribute, dispense, conduct research, or otherwise handle the controlled substances in the schedules for which you are applying under the laws of the **state** or jurisdiction in which you are operating or propose to operate.

MANDATORY

State License Number

Grid for State License Number

Which state or jurisdiction issued these licenses? _____ Expiration Date: / /
MM - DD - YYYY

SECTION 5 LIABILITY (All questions in this section must be answered.)

YES NO

1. Has the applicant ever been **convicted of a crime** in connection with controlled substances(s) under state or federal law?

Date(s) of incident MM-DD-YYYY: _____

YES NO

2. Has the applicant ever been excluded or directed to be excluded from participation in a Medicare or state health care program, or is any such action pending?

Date(s) of incident MM-DD-YYYY: _____

YES NO

3. Has the applicant ever surrendered (for cause) or had a **federal** controlled substance registration revoked, suspended, restricted, or denied or is any such action pending?

Date(s) of incident MM-DD-YYYY: _____

YES NO

4. Has the applicant ever surrendered (for cause) or had a **state** professional license or controlled substance registration revoked, suspended, denied, restricted, or placed on probation, or is any such action pending?

Date(s) of incident MM-DD-YYYY: _____

YES NO

5. If the applicant is a corporation (other than a corporation whose stock is owned and traded by the public), association, partnership, or pharmacy has any officer, partner, stockholder, or proprietor been convicted of a crime in connection with controlled substance(s) under state or federal law, or ever surrendered, for cause, or had a federal controlled substance registration revoked, suspended, restricted, denied, or ever had a state professional license or controlled substance registration revoked, suspended, denied, restricted or placed on probation, or is any such action pending?

Date(s) of incident MM-DD-YYYY: _____ *Note: If question 5 does not apply to you, be sure to mark 'NO'!*

EXPLANATION OF "YES" ANSWERS

Applicants who have answered "YES" to any question above must provide an explanation.

Liability question # _____ Location(s) of incident: _____

Nature of incident (if necessary, attach a separate sheet and return with application):

Disposition of incident:

SECTION 6 EXEMPTION FROM APPLICATION FEE

Check this box if the applicant is a federal, state, or local government official or institution. Does not apply to contractor-operated institutions.

Business or Facility Name of Fee Exempt Institution. **Be sure to enter the address of this exempt institution in Section 1.**

Grid for Business or Facility Name of Fee Exempt Institution

FEE EXEMPT CERTIFIER

The undersigned hereby certifies that the applicant named hereon is a federal, state or local government official or institution, and is exempt from payment of the application fee.

Provide the name, email and phone number of the certifying official

Signature of certifying official (**other than applicant**)

Date

Print or type name and title of certifying official

Telephone No. (required for verification)

Email address of certifying official

SECTION 7

METHOD OF PAYMENT

Check one form of payment only

Check Make check payable to: **Drug Enforcement Administration**
See page 4 of instructions for important information.

American Express Discover Master Card Visa

Credit Card Number

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Sign if paying by credit card

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Mail this form with payment to:

DEA Headquarters
ATTN: Registration Section/ODR
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Springfield, VA 22152-2639

FEE IS NON-REFUNDABLE

SECTION 8

APPLICANT'S SIGNATURE

Sign in ink

I certify that the foregoing information furnished on this application is true and correct.

Signature of applicant (**sign in ink**)

Date

Print or type name and title of applicant

WARNING: 21 USC 843(d), states that any person who knowingly or intentionally furnishes false or fraudulent information in the application is subject to a term of imprisonment of not more than 4 years, and a fine under Title 18 of not more than \$250,000, or both.

SECTION 1. APPLICANT IDENTIFICATION - Information must be typed or printed in the blocks provided to help reduce data entry errors. A physical address is required in address line 1; a post office box or continuation of address may be entered in address line 2. Fee exempt applicant must list the address of the federal or state fee exempt institution.

Applicant must enter a valid social security number (SSN), or a tax identification number (TIN) if applying as a business entity. **Debt collection information is mandatory pursuant to the Debt Collection Improvement Act of 1996.**

The email address, point of contact, national provider id, date of birth, year graduated, and professional school are new data items that are used to facilitate communication or as required by inter-agency data sharing requirements. They are requested in order to facilitate communication or as required by inter-agency data sharing requirements.

Practitioner must enter one degree from this list: DDS, DMD, DO, DPM, DVM, or MD.

Mid-level practitioner must enter one degree from this list: DOM, HMD, MP, ND, NP, OD, PA, or RPH.

SECTION 2. BUSINESS ACTIVITY - Indicate only one. Practitioner or mid-level practitioner must enter the degree conferred, and are requested to enter the last professional school of matriculation and the year graduated.

Automated dispensing system (ADS) must provide current DEA registration number of parent retail pharmacy or hospital, and attach a **notarized** affidavit in accordance with 21 CFR Part 1301.17. Affidavit must include:

1. Name of parent retail pharmacy or hospital and complete address
2. Name of Long-term Care (LTC) facility and complete address
3. Permit or license number(s) and date issued of State certification to operate ADS at named LTC facility
4. Required Statement:

This affidavit is submitted to obtain a DEA registration number. If any material information is false, the Administrator may commence proceedings to deny the application under section 304 of the Act (21 U.S.C. 8224(a)). Any false or fraudulent material information contained in this affidavit may subject the person signing this affidavit, and the named corporation/partnership/business to prosecution under section 403 of the Act (21 U.S.C 843).

5. Name of corporation operating the retail pharmacy or hospital
6. Name and title of corporate officer signing affidavit
7. Signature of authorized officer

SECTION 3. DRUG SCHEDULES - Applicant should check all drug schedules to be handled. However, applicant must still comply with state requirements; federal registration does not overrule state restrictions. Check the order form box only if you intend to purchase or to transfer schedule 2 controlled substances. Order forms will be mailed to the registered address following issuance of a Certificate of Registration. The following list of drug codes are examples of controlled substances for narcotic and non-narcotic schedules 2, 3, 4, and 5. Refer to the CFR for a complete list of basic classes.

SCHEDULE 2 NARCOTIC	BASIC CLASS	SCHEDULE 3 NARCOTIC	BASIC CLASS	SCHEDULE 4	BASIC CLASS
Alphaprodine (Nisentil)	9010	Buprenorphine (Buprenex, Temgesic, Subutex)	9064	Alprazolam (Xanax)	2882
Anileridine (Leritine)	9020	Codeine combo product up to 90 mg/du (Empirin)	9804	Barbital (Veronal, Plexonal, Barbitone)	2145
Cocaine (Methyl Benzoyllecgonine)	9041	Dihydrocodeine combo prod 90 mg/du (Compal)	9807	Chloral Hydrate (Noctec)	2465
Codeine (Morphine methyl ester)	9050	Ethylmorphine combo product 15 mg/du	9808	Chlordiazepoxide (Librium, Libritabs)	2744
Dextropropoxyphene (bulk)	9273	Hydrocodone combo product (Lorcet, Vicodin)	9806	Clorazepate (Tranxene)	2768
Diphenoxylate	9170	Morphine combo product 50 mg/100ml or gm	9810	Dextropropoxyphene du (Darvon)	9278
Diprenorphine (M50-50)	9058	Opium combo product 25 mg/du (Paregoric)	9809	Diazepam (Valium, Diastat)	2765
Ethylmorphine (Dionin)	9190	SCHEDULE 3 NON-NARCOTIC	BASIC CLASS	Diethylpropion (Tenuate, Tepanil)	1610
Etorphine Hydrochloride (M-99)	9059	Anabolic Steroids	4000	Difenoxin 1mg/25ug atropine SO4/du (Motofen)	9167
Glutethimide (Doriden, Dorimide)	2550	Benzphetamine (Didrex, Inapetyl)	1228	Fenfluramine (Pondimin, Dexfenfluramine)	1670
Hydrocodone (Dihydrocodeinone)	9193	Butalbital (Fiorinal, Butalbital w/aspirin)	2100/2165	Flurazepam (Dalmene)	2767
Hydromorphone (Dialuidid)	9150	Dronabinol in sesame oil w/soft gelatin capsule	7369	Halazepam (Paxipam)	2762
Levo-alphaacetylmethadol (LAAM)	9648	Gamma Hydroxybutyric Acid preps (Zyrem)	2012	Lorazepam (Ativan)	2885
Levorphanol (Levo-Dromoran)	9220	Ketamine (Ketaset)	7285	Mazindol (Sanorex, Mazanor)	1605
Meperidine (Demerol, Mepergan)	9230	Methypylon (Noludar)	2575	Mebutamate (Capla)	2800
Methadone (Dolophine, Methadose)	9250	Pentobarbital suppository du & noncontrolled active ingred. (FP-3, WANS)	2271	Meprobamate (Miltown, Equanil)	2820
Morphine (MS Contin, Roxanol)	9300	Phendimetrazine (Plegine, Bontril, Stabotex)	1615	Methohexital (Brevital)	2264
Opium, powdered	9639	Secobarbital suppository du & noncontrolled active ingredients	2316	Methylphenobarbital (Mebaral)	2250
Opium, raw	9600	Thiopental (Pentothal)	2100/2329	Midazolam (Versed)	2884
Oxycodone (Oxycontin, Percocet)	9143	Vinbarbital (Delvinal)	2100/2329	Oxazepam (Serax, Serenid-D))	2835
Oxymorphone (Numorphan)	9652			Paraldehyde (Paral)	2585
Opium Poppy / Poppy Straw	9650	SCHEDULE 5	BASIC CLASS	Pemoline (Cylert)	1530
Poppy Straw Concentrate	9670	Codeine Cough Preparation (Cosanyl, Pediacof)	9050	Pentazocine (Talwin, Talacen)	9709
Thebaine	9333	Difenoxin Preparation (Motofen)	9167	Phenobarbital (Luminal, Donnatal)	2285
SCHEDULE 2 NON-NARCOTIC	BASIC CLASS	Dihydrocodeine Preparation (Cophene-S)	9120	Phentermine (Ionamin, Fastin, Zantryl)	1640
Amobarbital (Amytal, Tuinal)	2125	Diphenoxylate Preparation (Lomotil, Logen)	9170	Prazepam (Centrax)	2764
Amphetamine (Dexedrine, Adderall)	1100	Ethylmorphine Preparation	9190	Quazepam (Doral)	2881
Methamphetamine (Desoxyn)	1105	Opium Preparation (Kapectolin PG)	9809	Temazepam (Restoril)	2925
Methylphenidate (Concerta, Ritalin)	1724			Triazolam (Halcion)	2887
Pentobarbital (Nembutal)	2270			Zolpidem (Ambien, Ivadal, Stilnox)	2783
Phencyclidine (PCP)	7471				
Phenmetrazine (Preludin)	1631				
Phenylacetone	8501				
Secobarbital (Seconal)	2315				

SECTION 4. STATE LICENSE(S) - Federal registration by DEA is based upon the applicant's compliance with applicable state and local laws. Applicant should contact the local state licensing authority prior to completing this application. If your state requires a separate controlled substance number, provide that number on this application.

SECTION 5. LIABILITY - Applicant must answer all four questions for the application to be accepted for processing. If you answer "Yes" to a question, provide an explanation in the space provided. If you answer "Yes" to several of the questions, then you must provide a separate explanation describing the date, location, nature, and result of each incident. If additional space is required, you may attach a separate page.

SECTION 6. EXEMPTION APPLICATION FEE - Exemption from payment of application fee is limited to federal, state or local government official or institution. The applicant's superior or agency officer must certify exempt status. The signature, authority title, and telephone number of the certifying official (other than the applicant) must be provided. The address of the fee exempt institution must appear in Section 1.

SECTION 7. METHOD OF PAYMENT - Indicate the desired method of payment. Make checks payable to "Drug Enforcement Administration". Third-party checks or checks drawn on foreign banks will not be accepted. **FEES ARE NON-REFUNDABLE.**

SECTION 8. APPLICANT'S SIGNATURE - Applicant **MUST** sign in this section or application will be returned. Card holder signature in section 7 does not fulfill this requirement.

Notice to Registrants Making Payment by Check

Authorization to Convert Your Check: If you send us a check to make your payment, your check will be converted into an electronic fund transfer. "Electronic fund transfer" is the term used to refer to the process in which we electronically instruct your financial institution to transfer funds from your account to our account, rather than processing your check. By sending your completed, signed check to us, you authorize us to copy your check and to use the account information from your check to make an electronic fund transfer from your account for the same amount as the check. If the electronic fund transfer cannot be processed for technical reasons, you authorize us to process the copy of your check.

Insufficient Funds: The electronic funds transfer from your account will usually occur with 24 hours, which is faster than a check is normally processed. Therefore, make sure there are sufficient funds available in your checking account when you send us your check. If the electronic funds transfer cannot be completed because of insufficient funds, we may try to make the transfer up to two more times.

Transaction Information: The electronic fund transfer from your account will be on the account statement you receive from your financial institution. However, the transfer may be in a different place on your statement than the place where your checks normally appear. For example, it may appear under "other withdrawals" or "other transactions." You will not receive your original check back from your financial institution. For security reasons, we will destroy your original check, but we will keep a copy of the check for record-keeping purposes.

Your Rights: You should contact your financial institution immediately if you believe that the electronic fund transfer reported on your account statement was not properly authorized or is otherwise incorrect. Consumers have protections under Federal law called the Electronic Fund Transfer Act for an unauthorized or incorrect electronic fund transfer.

ADDITIONAL INFORMATION

No registration will be issued unless a completed application has been received (21 CFR 1301.13).

In accordance with the Paperwork Reduction Act of 1995, no person is required to respond to a collection of information unless it displays a valid OMB control number. The OMB number for this collection is 1117-0014. Public reporting burden for this collection of information is estimated to average 12 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information.

The Debt Collection Improvements Act of 1996 (31 U.S.C. §7701) requires that you furnish your Taxpayer Identification Number (TIN) or Social Security Number (SSN) on this application. This number is required for debt collection procedures if your fee is not collectible.

PRIVACY ACT NOTICE: Providing information other than your SSN or TIN is voluntary; however, failure to furnish it will preclude processing of the application. The authorities for collection of this information are §§302 and 303 of the Controlled Substances Act (CSA) (21 U.S.C. §§822 and 823). The principle purpose for which the information will be used is to register applicants pursuant to the CSA. The information may be disclosed to other Federal law enforcement and regulatory agencies for law enforcement and regulatory purposes, State and local law enforcement and regulatory agencies for law enforcement and regulatory purposes, and persons registered under the CSA for the purpose of verifying registration. For further guidance regarding how your information may be used or disclosed, and a complete list of the routine uses of this collection, please see the DEA System of Records Notice "Controlled Substances Act Registration Records" (DEA-005), 52 FR 47208, December 11, 1987, as modified.

**Your Local
DEA Office**

CONTACT INFORMATION

All offices are listed on web site
(800, 877, and 888 are toll-free)

INTERNET

www.deadiversion.usdoj.gov

TELEPHONE

HQ Call Center (800) 882-9539

WRITTEN INQUIRIES:

DEA
Attn: Registration Section/ODR
P.O. Box 2639
Springfield, VA 22152-2639