Form-224

APPLICATION FOR REGISTRATION
Under the Controlled Substances Act

APPROVED OMB NO 1117-0014
FORM DEA-224 (10-20)

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 :

Do you have other DEA registration numbers?

☐ NO ☐ YES

MAIL-TO ADDRESS Please print mailing address changes to the right of the address in this box.

FEE FOR THREE (3) YEARS IS $888
FEE IS NON-REFUNDABLE

SECTION 1 APPLICANT IDENTIFICATION

☐ **Individual Registration** ☐ **Business Registration**

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

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

PLACE OF BUSINESS Street Address Line 1

PLACE OF BUSINESS Address Line 2

City State Zip Code

Business Phone Number

Point of Contact

Cell Phone Number

Email Address (one email address only, this address is for receiving renewal and other registration notices)

DEBT COLLECTION INFORMATION

Mandatory pursuant to Debt Collection Improvements Act

Social Security Number (***if registration is for individual***)

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

Tax Identification Number (***if registration is for business***)

FOR Practitioner or MLP ONLY:

Professional Degree (select from list only):

Professional School:

Year of Graduation:

National Provider Identification:

Date of Birth (*MM-DD-YYYY*): M M - D D - Y Y Y Y

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
☐ Emergency Medical Services
☐ Animal Shelter
☐ Hospital/Clinic Teaching
☐ Institution

FOR Automated Dispensing System (ADS) ONLY:

DEA Registration # of Retail Pharmacy for this ADS

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

STATE LICENSE

MANDATORY

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 Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiration Date: ___ / ___ / ______ MM - DD - YYYY

Which state or jurisdiction issued this license? ______________________________

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

1. Has the applicant ever been **convicted of a crime** in connection with controlled substance(s) under state or federal law or is any such action pending? YES ☐ NO ☐
   Date(s) of incident MM-DD-YYYY: ________________________________
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: ________________________________
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: ________________________________
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: ________________________________
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.**

☐☐☐

FEE EXEMPT CERTIFIER

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

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.

______________________________ 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 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiration Date ☐☐ - ☐☐

Sign if paying by credit card

______________________________ Signature of Card Holder

______________________________ Printed Name of Card Holder

Mail this form with payment to:

DEA Headquarters
ATTN: Registration Section/DRR
P.O. Box 2639
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 4

STATE LICENSE(S)

MANDATORY

Be sure to include both state license numbers

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 Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiration Date ___ / ___ / ___ MM - DD - YYYY

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 substance(s) under state or federal law or is any such action pending? Date(s) of incident MM-DD-YYYY: ______________________	☐	☐
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: ______________________	☐	☐
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: ______________________	☐	☐
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: ______________________	☐	☐
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.**

☐☐

FEE EXEMPT CERTIFIER

Provide the name and phone number of the certifying official

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.

______________________ Signature of certifying official (**other than applicant**) ______________ Date

______________________ 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 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiration Date ☐☐ - ☐☐

Sign if paying by credit card

______________________ Signature of Card Holder

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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.

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 USC 8224a). 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 USC 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
Alphaprodine (Nisentil)	9010
Anileridine (Leritine)	9020
Cocaine (Methyl Benzoylecgonine)	9041
Codeine (Morphine methyl ester)	9050
Dextropropoxyphene, bulk	9273
Diphenoxylate	9170
Diprenorphine (M50-50)	9058
Ethylmorpine (Dionin)	9190
Etorphine HCL (M-99)	9059
Glutethimide (Doriden, Dorimide)	2550
Hydrocodone (Dihydrocodeinone)	9193
Hydromorphone (Dilaudid)	9150
Levo-alphacetylmethadol (LAAM)	9648
Levorphanol (Levo-Dromoran)	9220
Meperidine (Demerol, Mepergan)	9230
Methadone (Dolophine, Methadose)	9250
Morphine (MS Contin, Roxanol)	9300
Opium, powdered	9639
Opium, raw	9600
Oxycodone (Oxycontin, Percocet)	9143
Oxymorphone (Numorphan)	9652
Opium Poppy/ Poppy Straw	9650
Poppy Straw Concentrate	9670
Thebaine	9333

SCHEDULE 2 NON-NARCOTIC	BASIC CLASS
Amobarbital (Amytal, Tuinal)	2125
Amphetamine (Dexedrine, Adderall)	1100
Methamphetamine (Desoxyn)	1105
Methylphenidate (Concerta, Ritalin)	1724
Pentobarbital (Nembutal)	2270
Phencyclidine	7471
Phenmetrazine (Preludin)	1631
Phenylacetone	8501
Secobarbital (Seconal)	2315

SCHEDULE 3 NARCOTIC	BASIC CLASS
Buprenorphine (Buprenex, Temgesic, Subutex)	9064
Codeine combo product 90mg/du (Empirin)	9804
Dihydrocodeine combo prod 90mg/du (Compal)	9807
Ethylmorphine combo product 15 mg/du	9808
Morphine combo product 50 mg/100 ml or gm	9810
Opium combo product 25 mg/du (Paregoric)	9809

SCHEDULE 3 NON-NARCOTIC	BASIC CLASS
Anabolic Steroids	4000
Benzphetamine (Didrex, Inapetyl)	1228
Butalbital (Fiorinal,Butalbital w/aspirin)	2100
Dronabinol in sesame oil w/soft gelatin capsule	7369
Gamma Hydroxybutyric Acid preps (Zyrem)	2012
Ketamine (Ketaset)	7285
Methyprylon (Noludar)	2575
Pentobarbital suppository du & noncontrolled active ingred (FP-3, WANS)	2271
Phendimetrazine (Plegine, Bontril, Statobex)	1615
Secobarbital suppository du & noncontrolled active ingredients	2316
Thiopental (Pentothal)	2100
Vinbarbital (Delvinal)	2100

SCHEDULE 5	BASIC CLASS
Codeine Cough Preparation (Cosanyl, Pediacof)	9050
Difenoxin Preparation (Motofen)	9167
Dihydrocodeine Preparation (Cophene-S)	9120
Diphenoxylate Preparation (Lomotil, Logen)	9170
Ethylmorphine Preparation	9190
Opium Preparation (Kapectolin PG)	9809

SCHEDULE 4	BASIC CLASS
Alprazolam (Xanax)	2882
Barbital (Veronal, Plexonal,Barbitone)	2145
Chloral Hydrate (Noctec)	2465
Chlordiazepoxide (Librium, Libritabs)	2744
Clorazepate (Tranxene)	2768
Dextropropoxyphene du (Darvon)	9278
Diazepam (Valium, Diastat)	2765
Diethylpropion (Tenuate, Tepanil)	1610
Difenoxin 1 mg/25ug ATSO4/du (Motofen)	9167
Fenfluramine (Pondimin, Dexfenfluramine)	1670
Flurazepam (Dalmane)	2767
Halazepam (Paxipam)	2762
Lorazepam (Ativan)	2885
Mazindol (Sanorex, Mazanor)	1605
Mebutamate (Capla)	2800
Meprobamate (Miltown, Equanil)	2820
Methohexital (Brevital)	2264
Methylphenobarbital (Mebaral)	2250
Midazolam (Versed)	2884
Oxazepam (Serax, Serenid-D)	2835
Paraldehyde (Paral)	2585
Pemoline (Cylert)	1530
Pentazocine (Talwin, Talacen)	9709
Phenobarbital (Luminal, Donnatal)	2285
Phentermine (Ionamin, Fastin, Zantryl)	1640
Prazepam (Centrax)	2764
Quazepam (Doral)	2881
Temazepam (Restoril)	2925
Triazolam (Halcion)	2887
Zolpidem (Ambiem, Ivadal, Stilnox)	2783

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 five 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 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 FROM 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 within 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 more two 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 principal 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/DRR
P.O. Box 2639
Springfield, VA 22152-2639