

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 \$888

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

State

Zip Code

City, State, Zip Code input fields

Business Phone Number

Point of Contact

Business Phone Number and Point of Contact input fields

Cell Phone Number

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

Cell Phone Number and Email Address input fields

DEBT COLLECTION INFORMATION

Social Security Number (if registration is for individual)

Tax Identification Number (if registration is for business)

Mandatory pursuant to Debt Collection Improvements Act

Social Security Number input field

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

Tax Identification Number input field

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, Emergency Medical Services, 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**

**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]

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?
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.

[Grid for Business or Facility Name]

**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

Expiration Date

[Grid for Credit Card Number]

[Grid for 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**

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.)

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, 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 of Fee Exempt Institution

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/DRR  
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**

Sign in ink

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	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 90mg/du (Empirin)	9804	Barbital (Veronal, Plexonal, Barbitalone)	2145
Cocaine (Methyl Benzoylcocgonine)	9041	Dihydrocodeine combo prod 90mg/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	Morphine combo product 50 mg/100 ml or gm	9810	Clorazepate (Tranxene)	2768
Diphenoxylate	9170	Opium combo product 25 mg/du (Paregoric)	9809	Dextropropoxyphene du (Darvon)	9278
Diprenorphine (M50-50)	9058			Diazepam (Valium, Diastat)	2765
Ethylmorphine (Dionin)	9190	<b>SCHEDULE 3 NON-NARCOTIC</b>	<b>BASIC CLASS</b>	Diethylpropion (Tenuate, Tepanil)	1610
Etorphine HCL (M-99)	9059	Anabolic Steroids	4000	Difenoxin 1 mg/25ug ATSO4/du (Motofen)	9167
Glutethimide (Doriden, Dorimide)	2550	Benzphetamine (Didrex, Inapetyl)	1228	Fenfluramine (Pondimin, Dexfenfluramine)	1670
Hydrocodone (Dihydrocodeinone)	9193	Butalbital (Fiorinal, Butalbital w/aspirin)	2100	Flurazepam (Dalmane)	2767
Hydromorphone (Dilaudid)	9150	Dronabinol	7369	Halazepam (Paxipam)	2762
Levo-alphaacetylmethadol (LAAM)	9648	in sesame oil w/soft gelatin capsule		Lorazepam (Ativan)	2885
Levorphanol (Levo-Dromoran)	9220	Gamma Hydroxybutyric Acid preps (Zyrem)	2012	Mazindol (Sanorex, Mazanor)	1605
Meperidine (Demerol, Mepergan)	9230	Ketamine (Ketaset)	7285	Mebutamate (Capla)	2800
Methadone (Dolophine, Methadose)	9250	Methyprylon (Noludar)	2575	Meprobamate (Miltown, Equanil)	2820
Morphine (MS Contin, Roxanol)	9300	Pentobarbital suppository du	2271	Methohexital (Brevital)	2264
Opium, powdered	9639	& noncontrolled active ingred (FP-3, WANS)		Methylphenobarbital (Mebaral)	2250
Opium, raw	9600	Phendimetrazine (Plegine, Bontril, Statobex)	1615	Midazolam (Versed)	2884
Oxycodone (Oxycontin, Percocet)	9143	Secobarbital suppository du	2316	Oxazepam (Serax, Serenid-D)	2835
Oxymorphone (Numorphan)	9652	& noncontrolled active ingredients		Paraldehyde (Paral)	2585
Opium Poppy/ Poppy Straw	9650	Thiopental (Pentothal)	2100	Pemoline (Cylert)	1530
Poppy Straw Concentrate	9670	Vinbarbital (Delvinal)	2100	Pentazocine (Talwin, Talacen)	9709
Thebaine	9333			Phenobarbital (Luminal, Donnatal)	2285
		<b>SCHEDULE 5</b>	<b>BASIC CLASS</b>	Phentermine (Ionamin, Fastin, Zantril)	1640
<b>SCHEDULE 2 NON-NARCOTIC</b>	<b>BASIC CLASS</b>			Prazepam (Centrax)	2764
Amobarbital (Amytal, Tuinal)	2125	Codeine Cough Preparation (Cosanyl, Pediacof)	9050	Quazepam (Doral)	2881
Amphetamine (Dexedrine, Adderall)	1100	Difenoxin Preparation (Motofen)	9167	Temazepam (Restoril)	2925
Methamphetamine (Desoxyn)	1105	Dihydrocodeine Preparation (Cophene-S)	9120	Triazolam (Halcion)	2887
Methylphenidate (Concerta, Ritalin)	1724	Diphenoxylate Preparation (Lomotil, Logen)	9170	Zolpidem (Ambien, Ivadal, Stilnox)	2783
Pentobarbital (Nembutal)	2270	Ethylmorphine Preparation	9190		
Phencyclidine	7471	Opium Preparation (Kapectolin PG)	9809		
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 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](http://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