DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
CENTER FOR SUBSTANCE ABUSE TREATMENT

Form Approved: OMB Number 0930-0206
Expiration Date: xx/xx/xxxx
See OMB Statement on Reverse

Application for Certification to Use Medications for the Treatment of Opioid Use Disorder in a Treatment Program Under 42 CFR § 8.11

DATE OF SUBMISSION

Note: This form is required by 42 CFR 8.11 pursuant to Sec. 303, Controlled Substances Act (21 USC § 823) and the Drug Abuse Prevention and Control Act of 1970 (42 USC § 275(a)). Failure to report may result in a recommendation for the suspension or revocation of the opioid treatment program registration.

1a. Name of Program or Name Change: (Name of primary dispensing location)

1d. DEA Registration Number:

1b. Doing business as:

1c. Opioid Treatment Program Number: (e.g., AL-10001-M)

2. Address of Primary Dispensing Location: (Include ZIP Code)

3. Telephone Number: (Include Area Code)

4. E-Mail Address:

5. Name and Address of Program Sponsor: (Include ZIP Code)

6. Telephone Number: (Include Area Code)

7. E-Mail Address:

8. Name of Medical Director: (and Address—if different than Dispensing Location, above)

9. DEA Registration Number:

10. Telephone Number: (Include Area Code)

11. E-Mail Address:

12. Purpose of Application*:

☐ Provisional Certification ☐ Renewal/Re-certification ☐ New Sponsor ☐ New Medical Director ☐ Relocation ☐ Medication Unit

13a. Medication Type (Check each appropriate medication.)	**13b. Number of patients treated with each medication on date of submission**
☐ Methadone	_____
☐ Buprenorphine	_____
☐ Naltrexone	_____
☐ Other (Specify)	_____

14a. Program Status: ☐ For-profit ☐ Nonprofit ☐ Public/Government ☐ VA ☐ Carceral ☐ Tribal ☐ Other (Specify) _____

14b. Program Funding Sources: (Check each appropriate agency and attach the address of each, if applicable.)

☐ SAMHSA (Block Grant) ☐ Private Charities ☐ Department of Veterans Affairs

☐ Patient Payment ☐ State Government ☐ County Government

☐ Indian Health Service ☐ Private Health Insurance ☐ Other (Specify) _____

Program Sponsor: (Signature)

Date:

The preferred method for submitting this form to CSAT/DPT for a provisional certification is electronically at SAMHSA.gov which contains complete instructions for preparing and submitting your request,* http://dpt2.samhsa.gov/sma162 . Submission of the SMA-162 for provisional certification and other purposes named in item #12 above are described here: http://www.samhsa.gov/medication-assisted-treatment/opioid-treatment-programs/apply. It is highly encouraged that submission take place in this capacity. *If you are unable to submit online, please contact the helpdesk at OTP-Help@jbsinternational.com. Additional information can be found at https://www.samhsa.gov/medications-substance-use-disorders .

Division of Pharmacologic Therapies
Substance Abuse and Mental Health Services Administration
Attention: OTP Certification Program 5600 Fishers Lane
Rockville, MD 20857

Paperwork Reduction Act Statement

Public reporting burden for this collection of information is estimated to average between 6 minutes and 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering, and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0206); 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0206.