



Government of the District of Columbia
Department of Health
Health Regulations and Licensing Administration
DOH – Pharmacy
P.O. Box 37801
Washington D.C. 20013

FOR OFFICIAL USE ONLY!

Application Complete:
 YES NO
Approved Registration:
 YES NO

FOR OFFICIAL USE ONLY!

DATE: _____
REG NO: _____
INITIALS: _____



Controlled Substances Registration Application

Incomplete or illegible application packages will not be processed. Please refer to registration application instructions.

PLEASE PRINT LEGIBLY OR TYPE ALL ENTRIES

LAST NAME FIRST

NAME D.C. BUSINESS OR HOSPITAL AFFILIATION NAME

D.C. BUSINESS OR HOSPITAL AFFILIATION ADDRESS (DO NOT USE PO BOX)

CITY STATE

ZIP PHONE NUMBER

FAX NUMBER

1. BUSINESS ACTIVITY: CHECK ONLY ONE

- | | | | |
|---|---|-------------------------------------|--|
| <input type="checkbox"/> Manufacturer | <input type="checkbox"/> Distributor | <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Hospital/Clinic |
| <input type="checkbox"/> Analytical Lab | <input type="checkbox"/> Importer/Exporter | <input type="checkbox"/> Researcher | <input type="checkbox"/> Practitioner |
| <input type="checkbox"/> Maintenance and/or
Detoxification | <input type="checkbox"/> Teaching Institution | <input type="checkbox"/> Other: | Specify Health Degree: _____ |

2. ALL APPLICANTS MUST ANSWER THE FOLLOWING:

(a) Is the applicant currently authorized to prescribe, manufacture, distribute, conduct research or instructional activities or chemical analysis with or otherwise handle the controlled substances in the schedules for which you are applying for, under the laws of District of Columbia?

- Yes – D.C. License Number: _____
 Not Applicable

(b) Has the applicant ever been convicted of a felony in connection with controlled substances (CS) under D.C., State or Federal law, or ever surrendered or had a CS registration revoked, or suspended or denied? YES NO

(c) If the applicant is a corporation, association or partnership, has any officer, partner, stockholder or proprietor been convicted of a felony in connection with CS under D.C., State or Federal law, or ever surrendered or had a CS registration revoked, or suspended or denied? YES NO

IF THE ANSWER TO QUESTIONS (b) AND/OR (c) IS YES, INCLUDE A SIGNED STATEMENT EXPLAINING SUCH RESPONSES.

MAIL THIS APPLICATION TO ABOVE ADDRESS

Initial Application

Renewal Application – Registration Number _____

To have registration mailed to another address other than the business address, please provide mailing address

LAST NAME FIRST NAME

MAILING ADDRESS

CITY STATE ZIP

3. CONTROLLED SUBSTANCE SCHEDULES:

Check all applicable controlled substances schedules in which you intend to handle.

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Schedule I | <input type="checkbox"/> Schedule II | <input type="checkbox"/> Schedule III (Narcotic) |
| <input type="checkbox"/> Schedule III (Non-Narcotic) | <input type="checkbox"/> Schedule IV | <input type="checkbox"/> Schedule V |

4. CERTIFICATION FOR FEE EXEMPTION

CHECK IF INDIVIDUAL NAMED HEREON IS A D.C. OFFICIAL

The undersigned hereby certifies that the applicant hereon is an officer or employee of a local D.C. agency who, in the course of such employment, is authorized to obtain, dispense, prescribe, or otherwise handle controlled substances.

Signature of Certifying Official

Date

Print Certifying Official's Name and Title

Name of Governmental Institution and Agency

5. I CERTIFY THAT ALL OF THE STATEMENTS MADE ARE TRUE, COMPLETE, AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature of Applicant or Authorized Individual

Print Name and Title

Date