GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Health Regulations and Licensing Administration
Pharmaceutical Control

Mail application to: (DOH-Pharmacy P.O.Box 37801, Washington DC 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-Health Professionals

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

EMAIL 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

1. BUSINESS ACTIVITY: CHECK ONLY ONE ☐

☐ Manufacturer ☐ Distributor ☐ Pharmacy ☐ Hospital/Clinic
☐ Analytical Lab ☐ Importer/Exporter ☐ Researcher ☐ Practitioner
☐ Maintenance and/or Detoxification ☐ Teaching Institution ☐ 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.

3. CONTROLLED SUBSTANCE SCHEDULES:

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

☐ Schedule I ☐ Schedule II ☐ Schedule III (Narcotic)
☐ Schedule III (Non-Narcotic) ☐ Schedule IV ☐ 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