



**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
**Department of Health**  
**Health Regulations and Licensing Administration**  
**Pharmaceutical Control**  
**899 North Capitol Street, NE Washington DC 20002**

**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

\_\_\_\_\_  
 EMAIL ADDRESS

**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.**

**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.

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