Commonwealth of Massachusetts
Department of Public Health, Bureau of Health Professions Licensure
Drug Control Program
239 Causeway Street, Suite 500, Boston, MA 02114
Telephone 617-973-0949 Fax 617-753-8233

Application for Massachusetts Controlled Substances Registration for Advanced Practice Registered Nurses and Physician Assistants

Please be sure to:

- Mail completed application, sides 1 and 2, along with required documentation;
- Include copies of each current supervising physician(s)' Massachusetts Controlled Substances Registration (MCSR) and federal DEA registration;
- Have the applicant sign (not initial) and date the form at the bottom of second page;
- Have the supervising physician sign (not initial) and date the form in the "Supervising Physician Information section" (does not apply to certified Nurse Midwives.); and
- Enclose check or money order for $150.00 made payable to "Commonwealth of Massachusetts".

The Department will make every effort to process your application as quickly as possible. Please note that processing may take 10 business days from receipt of application. Incomplete applications will be returned and will cause a delay in receiving your MCSR. For further information, visit: http://www.mass.gov/dph/dcp.

Application Type: (Please select one) ☐ New ☐ Renewal

In the boxes below enter the requested information.

1) Classification: (Select one) ☐ CNP ☐ CNM ☐ PCNS ☐ CRNA ☐ PA

2) Massachusetts Board of Registration License No.:

3) DEA Controlled Substance Registration No. (If issued/ possessed):

4) Name:

First: Middle: Last:

Suffix: (e.g. Jr., Sr., II, III)

5) Applicant Business Address:
Applications with a P.O. Box number and no street address cannot be processed. Out-of-state addresses require a letter of explanation. Registrations are site specific. List every business location where you practice. If you change or add a business address during the year, you are required to notify this program by submitting an amended information form.

Business/Facility Name (and Department if applicable):

Street:

City: State: ZIP:

6) Mailing Address: ☐ Check here if same as the Business Address

Facility Name and Department (if applicable):

Street:

City: State: ZIP:

7) Business Telephone No.:

8) Applicant's email address (must be specific to applicant, cannot be accessed by other persons):

9) Drug Schedules requested: Select all that apply: ❑ II ❑ III ❑ IV ❑ V ❑ VI
Schedule VI includes all prescription drugs not in Schedules II - V. Only Schedules that are checked can be authorized.

10) Social Security No.: (Required by M.G.L. c. 30A, s. 13A)

11) Have you ever been convicted of any violation of State or Federal law relating to the manufacture, possession, distribution or dispensing of controlled substances? ☐ Yes * ☐ No

12) Has any previous professional license or registration held by you under any name or corporate name or legal entity been surrendered, revoked, suspended or denied or is such action pending? ☐ Yes * ☐ No
* A Yes to Question No. 11) or No. 12), requires a letter of explanation attached to this form.

Supervising Physician Information:

Not required for Certified Nurse Midwives.	
13) The following Supervising Physician's Information must be completed by each physician who supervises your prescriptive practice. The supervising physician is the individual with whom you, the applicant, have developed and signed mutually agreed upon prescriptive guidelines. If you practice in more than one setting (e.g., more than one employer), you must complete this section for each physician that you have signed mutually agreed upon prescriptive guidelines in each setting. You may make photocopies of this page as necessary.	
Name of Supervising Physician:	Telephone No. ( ) area code
Business Address:	
Board of Medicine License No.:	Massachusetts Controlled Substances Registration No.:
DEA Controlled Substance Registration No.:	Medical Specialty:
Are there written prescriptive guidelines in place? ❑ Yes ❑ No ❑ N/A (Certified Nurse Midwives only) Written prescriptive guidelines are required for Advanced Practice Registered Nurses and Physician Assistants (Certified Nurse Midwives are not required to have prescriptive guidelines.) Applications checked "No" will be returned.	
Signature of Supervising Physician: ✘ _____ Date ✘ _____	

Applicant please sign and date below

I hereby certify that (1) the information on this application is true to the best of my knowledge; (2) I possess written prescriptive guidelines that were mutually developed, agreed upon, and signed by my supervising physician and me; and (3) I will comply with the laws of the Commonwealth of Massachusetts and all applicable rules and regulations of the Department of Public Health and either the Board of Registration in Nursing or the Board of Registration of Physician Assistants, whichever is applicable. I also certify, in accordance with M.G.L. c. 62C, section 49A, that I have to the best of my knowledge and belief complied with all laws of the commonwealth relating to taxes, reporting of employees and contractors, and withholding and remitting of child support. Signed under the pains and penalties of perjury.

Signature of applicant ✘ _____ Date ✘ _____

MCSR Application Form Instructions

These instructions follow the application form sequentially. If you need additional guidance contact the Drug Control Program (DCP) at 617-973-0949.

Questions:

1. Select your professional degree.
2. Fill in your the Board of Registration number.
3. Fill in your personal DEA number. An existing out-of-state DEA registration is acceptable for new applicants. However for renewed applicants a DEA registration with a Massachusetts business address is required. There are limited exceptions to this rule. Please provide a letter of explanation if you provide an out-of-state DEA number.
4. Include your complete middle name (no initials), and a suffix, if applicable.
5. Fill in your business address.
6. Fill in your mailing address. If you do not use fill in a mailing address, all mailings will go to your business address.
7. Fill in the phone number at which you can be reached. Please be mindful that this phone number would be used should DCP need to contact you or should prescribers or pharmacists need to consult with you regarding Massachusetts Prescription Awareness Tool (MassPAT) prescription histories.
8. Please provide an email address that you monitor frequently.
9. Check off the drug schedule privileges you are requesting. If you check of a higher schedule and leave any lower schedules unchecked, you will be granted privileges for the lower schedule also. For example, if you check off only Schedule II, you will also be granted privileges for Schedules III – VI.
10. Enter your social security number.
11. Check the "Yes" or the "No" box. If checking the "Yes" box, include a letter of explanation.
12. Check the "Yes" or the "No" box. If checking the "Yes" box, include a letter of explanation.
13. Enter the information with respect to the supervising physician(s) and have the supervising physician's sign and date this section. Attach a separate sheet with this section for each additional supervising physician. Nurse mid-wives are exempt from entering the supervising physician section.