



**Commonwealth of Massachusetts, Department of Public Health, Drug Control Program**  
**99 Chauncy Street, Boston, MA 02111**  
**Telephone 617 983-6700 Fax 617 753-8233**  
**Amended Information Application for Massachusetts Controlled Substances Registration for**  
**Advanced Practice Nurses and Physician Assistants**  
**(In Accordance with the Controlled Substances Act, M.G.L. Chapter 94C)**

No fee is charged when submitting this amended application form. Please be sure to:

- Complete information on both sides of this form.
- Sign (not initial) and date form.
- Have the supervising physician sign (not initial) and date this form if adding or amending his/her information.
- Include a photocopy of the current Massachusetts Board of Registration license for advanced practice nurse or physician assistant.
- Include photocopies of your current supervising physician(s)' Massachusetts Controlled Substances Registration and federal DEA Controlled Substance Registration Certificate if adding or amending that information. Where photocopied licenses and registrations are to be submitted, do not send originals. They will not be returned.

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 our Web site at <http://www.mass.gov/dph/dcp>.

**Amended Information Application**

Please fill out this form in its entirety. Place a check in the box to the left column to indicate information that is being amended.

Amended	In the boxes below enter the requested information.
<input type="checkbox"/>	1) Classification: (Select one) <input type="radio"/> CNP/NP <input type="radio"/> CNM/NM <input type="radio"/> PCNS/PC <input type="radio"/> CRNA/NA <input type="radio"/> PA
<input type="checkbox"/>	2) Massachusetts Board of Registration License No.:
<input type="checkbox"/>	3) DEA Controlled Substance Registration No. (If possessed):
<input type="checkbox"/>	4) Name: First: _____ Middle: _____ Last: _____ Suffix: (e.g. Jr., Sr., II, III)
<input type="checkbox"/>	5) Applicant Business Address: Amended applications that include a P.O. Box number without a street address cannot be processed. Out-of-state addresses require a letter of explanation. List every business location where you practice. If you change business addresses during the year, you are required to notify this program by submitting an Amended Application Information form. Facility Name and Department (if applicable): _____ Street: _____ City: _____ State: _____ ZIP: _____
<input type="checkbox"/>	6) Applicant Mailing Address: Facility Name and Department (if applicable): _____ Street: _____ City: _____ State: _____ ZIP: _____
<input type="checkbox"/>	7) Business Telephone No.: (    )
<input type="checkbox"/>	8) Social Security No.: (Required by M.G.L. c. 30A, s. 13A)
<input type="checkbox"/>	9) <b>Drug Schedules</b> requested: Select all that apply: <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V <input type="checkbox"/> VI Schedule VI includes all prescription drugs not in Schedules II - V. Only Schedules that are checked can be authorized.
<input type="checkbox"/>	10) E-mail Address:
<input type="checkbox"/>	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? <input type="checkbox"/> Yes * <input type="checkbox"/> No



