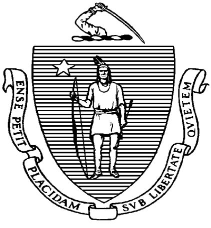

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
Drug Control Program
250 Washington Street, 3rd Floor
Boston, MA 02108

Tel: 617-973-0949
TTY : 617-973-0988
www.mass.gov/orgs/massachusetts-controlled-substances-registration

Advanced Practice Providers (PAs, CDTM pharmacists) must have a Supervising Physician in each of their practice settings. APRNs who do not meet the requirements for independent prescriptive practice) must have a Supervising Physician, or Qualified Healthcare Professional in each of their practice settings.

PLEASE SELECT ONE:

____ I certify that I am an APRN with a minimum of two years of supervised prescriptive practice **OR** at least two years independent prescriptive practice and meet the requirements of 244 CMR 4.00 to engage in independent prescriptive practice.

____ I certify that I am an APRN supervised by a physician or qualified healthcare professional who has independent practice authority pursuant to 244 CMR 4.07, and have written guidelines for my prescriptive practice as required by 105 CMR 700003(C)(d).

____ I certify that I am a Certified Nurse Midwife.

____ I certify that I am a PA or CDTM Pharmacist, supervised by a physician, and have written guidelines for my prescriptive practice as required by 105 CMR 700003(C)(d).

I hereby certify that, under pains and penalties of perjury, all of the information submitted in this form is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this form is grounds for MCSR revocation or denial of the MCSR and may subject me to civil or criminal penalties.

Print Name: ____________________________________ **Date:** __________________________

Board License No._________________________

Signature: _____________________________________