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|  | **Commonwealth of Massachusetts**  **Department of Public Health, Bureau of Health Professions Licensure Drug Control Program**  **250 Washington Street, Boston, MA 02108**  **Telephone 617-973-0949 Fax 617-753-8233**  **Application for MA Controlled Substances Registration to Manufacture or Distribute Controlled Substances** |
| Please be sure to:   * Submit completed application form. * Enclose check or money order for $300 made payable to “Commonwealth of Massachusetts”.   *There is no fee to submit a form with amended information.*   * Have form signed (not initialed) and dated. * Mail to the address above.   Incomplete applications will be returned causing a delay in issuance of the registration. Only send copies of supporting documents. Originals will not be returned. For further information visit: <http://www.mass.gov/dph/dcp> | |

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|  | II | III | IV | V | VI |
| Bulk Manufacturer, Synthesizer, Extractor |  |  |  |  |  |
| Dosage Form Manufacturer |  |  |  |  |  |
| Repacker - Relabeler |  |  |  |  |  |

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| Application Type: (Please select one) |  New |  Renewal |  Amended Information *(No fee)* |
| Registration Requested: |  Manufacture |  |  Distribute |

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| In the boxes below enter the requested information. | | | | | |
| 1) Applicant: (Company Name) | | | | | |
| 2) Applicant Business Address: (An application with a P.O. Box number and no street address cannot be processed.) Street:  City: State: ZIP: | | | | | |
| 3) Applicant Mailing Address: (If different than above) Street:  City: State: ZIP: | | | | | |
| 4) Business Telephone No.: ( )  area code | | | | | |
| 5) Federal Tax ID No.: (Required by M.G.L. c. 30A, s. 13A) | | | | | |
| 6) DEA Controlled Substance Registration No.: (If issued) | | | | | |
| 7) **Distributors** check 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. | | | | | |
| 8) **Manufacturers** check drug Schedules requested for each applicable category: | | | | | |
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| 9) Has the applicant ever been convicted of any violation of State or Federal law relating to the manufacture, possession, distribution or dispensing of controlled substances?  Yes \*  No | | | | | |

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| 10) Has any professional license or registration issued to the applicant under any name or corporate name or legal entity been surrendered, revoked, suspended or denied or is such action pending?  Yes \*  No |
| \* If you answered “Yes” to Question No. [9)](#_bookmark0) or No. [10),](#_bookmark1) a letter must be attached setting forth circumstances of such action(s). |

I hereby certify that the information on this application is true to the best of my knowledge, and that the applicant will comply with the laws of the Commonwealth of Massachusetts and all applicable rules and regulations promulgated by the Department of Public Health. I also certify, in accordance with M.G.L. c. 62C, section 49A, that the applicant has 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 authorized individual Date

Print Name:

Title:

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| For Office Use Only | |
| Application approved by: | Comments: |
| Date: |