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

Application to Amend Information for the Massachusetts Controlled Substances Registration (MCSR) for a Community Program (MAP)

Use this form to amend program contact information (Rows 4, 5, 6 and 8) or site capacity/site occupancy information (Row 11). All other changes require use of the New Application form.

Please be sure to:

- Check the row with amended information.
- Row 12 - Enter all information, sign (not initial) and date the application form.
- Mail to: 239 Causeway Street, Suite 500, Boston, MA 02114.

For further information visit our Web site at http://www.mass.gov/dph/dcp or call the Drug Control Program at 617-973-0949.

This amended information is for the registered MAP site at the following address:

Street:
City: State: ZIP:
Telephone: Fax: Email:

MCSR Number: MAP_____

Please check the box to the left of any row containing amended information. Row 10 must be completed and signed.

Amended	In the boxes below enter the amended information.
	1. This row intentionally left blank.
	2. This row intentionally left blank.
	3. This row intentionally left blank.
☐	4. **Mail Recipient (if not Operational Manager, Box 12):**
☐	5. **Service Provider Business Address**: (A P.O. Box number without a street address cannot be processed.) Street: City: State: ZIP: Telephone: Fax: Email:
☐	6. **Program Director (**Managerial Contact**) Name:** Street: City: State: ZIP: Telephone: Fax: Email:
	7. This row intentionally left blank.
☐	8. **Site Supervisor** (House Manager) **Name:** Telephone: Fax: Email:

	9. This row intentionally left blank.
☐	10. **Population(s)**: (Check both if applicable.) ☐ Adults (18 years of age or older) ☐ Youth (under 18 years of age)
☐	11. **Capacity:** (Enter number for occupancy.) Site current occupancy: _____ Site total capacity: _____

Service Provider Authorized Individual Information

12. **Service Provider Operational Manager (**e.g., Agency Director, Executive Director, CEO, President, etc.**)**

Contact Information:

Print name: Print title:

Street:

City: State: ZIP:

Telephone: Fax: Email:

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, s. 49A, that the applicant has to the best of my knowledge and belief filed all state tax returns and paid all state taxes required under law.

Signed under the pains and penalties of perjury.

Signature: _____ Date: _____

Authorized Individual --Service Provider Operational Manager (e.g., Agency Director, Executive Director, CEO, President, etc.)

For office use only		
Received by Drug Control Program	Comments	Staff initials