



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

**Massachusetts Controlled Substance Registration (MCSR)
Amended Information Form for Facilities**

MCSR Amended Information Form Instructions

Please read the following information carefully before completing the form:

1. This form is only intended for Massachusetts Controlled Substance Registrants who wish to change their email address and contact person.
2. This form does not apply to changes in address, or name of facility
3. Items with an asterisk are mandatory.
4. Attest to the form by signing and dating the second page. The Drug Control Program cannot accept amended information forms without a signature.
5. When complete, send the amended information form by either email, fax, or mail:

Email: MCSR@massmail.state.ma.us

Fax: 617-753-8233

Mail:

Bureau of Health Professions Licensure
Drug Control Program, Attn: MCSR
250 Washington Street, 3rd Floor
Boston, MA 02108

Carefully Print or Type the Following Information:

Facility Name*:	MCSR Number*:

Select Your MCSR Type*:

- Ambulance Service Analytical Lab Clinic Distributor/Manufacturer
 Health Care Entity Hospital Long Term Care Facility
 Municipality or Non-Municiple Public Agency Virtual Distributor/Manufacturer

MCSR Contact Information
Print or type your amended information (must be legible)
Contact Person: :
MCSR Business Phone Number:
MCSR Email Address:

I hereby certify that, under pains and penalties of perjury, all of the information submitted in this form, and attachments 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. My signature on this MCSR form attests under penalties of perjury that, to the best of my knowledge and belief, I have complied with: the laws of the Commonwealth of Massachusetts and all applicable rules and regulations of the Department of Public Health and the Drug Control Program.

Full Name: _____

Signature: _____

Date: _____