

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: 617-973-0800 TTY: 617-973-0988 www.mass.gov/dph/boards

Massachusetts Controlled Substance Registration (MCSR) Termination Form

Registrant Information									
MCSR	MCSR number:		Expiration [Expiration Date:					
Regist	Registrant Name:								
Email	Email Address:								
Addre	SS: No. Street	City	State/Country	Zip/Postal Code					
Please select the reason(s) for terminating your MCSR:									
☐ Addition of MCSR drug schedules* ☐ Change of MCSR business address* ☐ Retiring ☐ Terminated, revoked, voided by process of law or regulation ☐ Going out of business ☐ Other, please describe: * If you wish to add additional drug schedules or change your business address, you must apply for a new MCSR. We recommend applying for a new MCSR before terminating your existing MCSR.									
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riease	review and c	omplete as appropria	ate						
1.	I understand that my Massachusetts Controlled Substances Registration (MCSR) has been willingly terminated by me, or has been terminated or revoked, has become void due to process of law or regulation.								
2.	controlled su	bstances as part of a p	norized to prescribe, purchase, order, store, or administer of practice or research study in the sociated with this MCSR.						

3. 4.	I hereby certify that I have destroyed my MCSR that I am terminating with this form. I hereby affirm that I am no longer prescribing, ordering, storing, administering controlled substances associated with this MCSR and/or the business has closed effective					
	and (please check one of the below, as appropriate):					
☐ I have no controlled substances in my possession, custody or control pursuant to my former MCSR						
☐ I have attached a copy of my disposition plan showing appropriate legal disposition of the controlled substances which were in my possession, custody or control pursuant to my former professional practice.						
☐ I have applied for and received a new MCSR with the appropriate drug schedules and business address. The new MCSR # is:						
I h and	ay contify that under pains and papalties of pariumy all of the information submitted in this					

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.

Signature	 Date	

Please submit your Termination Form via 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, 3rdFloor Boston, MA 02108