

3. I hereby certify that I have destroyed my MCSR that I am terminating with this form.
4. 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):
Date

- 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 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