The Commonwealth of Massachusetts
Department of Public Health
Drug Control Program
Massachusetts Controlled Substance Registration (MCSR)
Application for Optometrists

Instructions

- To apply for an MCSR, you must have a valid corresponding license issued by a Board of Registration.
- Incomplete applications will be delayed, and may be denied.
- Submit check or money order for $150 made payable to: "COMMONWEALTH OF MA" and write Board License Number on front of payment. The following payment forms are not accepted: cash, foreign currency, electronic funds transfers, or payments using online banking services.
- Mail your application to:
  Bureau of Health Professions Licensure
  Drug Control Program, Attn: MCSR
  239 Causeway Street, 5th Floor Suite 500
  Boston, MA 02114
- Do not include any correspondence with application and payment. Send any additional correspondence to the attention of the Bureau of Health Professions Licensure Drug Control Program, Attn: MCSR, 239 Causeway Street, 5th Floor Suite 500, Boston, MA 02114, or email the Program MCSR@massmail.state.ma.us. Write your Board License Number on all correspondence.
- The Drug Control Program's Rules and Regulations (105 CMR 700, 720, 721, and 722) are available for review online at https://www.mass.gov/lists/laws-and-regulations-drug-control-program.

Important Information for MCSR/Business Address

- Every person who does more than prescribe at a site - who stores/orders, dispenses or administers controlled substances at a site – needs an MCSR associated with that site address.
- If a person only prescribes controlled substances and does not store/order, dispense, or administer controlled substances, that person needs just one MCSR. That MCSR can be used at multiple locations so long as the person is *only* prescribing at each location.
- Every site/business address which receives and stores controlled substances needs either a facility MCSR, or a person with an MCSR associated with that address who is responsible for those activities at that site.

Application Type: (Select one) ❑ New ❑ Additional Location ❑ Renewal

In the boxes below enter the requested information.
1a) Massachusetts Board of Registration License No.: 1b) Board of Registration License Original Issue Date:
2) Name (please ensure your name appears exactly as it does on your Board License) First: Middle (optional): Last: Suffix (optional): (e.g. Jr., Sr., II, III) Prefix (optional):
3) Date of Birth: (MM/DD/YY)
4) Social Security No.: (Required by M.G.L. c. 30A, s. 13A)
5) Personal telephone number (optional): 6) Personal email address (recommended): 7) Personal address, if different than business address provided for the business address: Street: City: State: ZIP:

8) MCSR Business Address:
Applications that include a P.O. Box number without a street address cannot be processed. Out-of-state addresses require a letter of explanation.

Facility Name and Department (if applicable):

Street:

City: State: ZIP:

9) MCSR Business telephone number (optional):

10) MCSR Business fax number (optional):

11) Business email address:
Note: You will receive important reminders and notices for your MCSR at this email address.

12) Drug Schedules: Only Schedule VI can be authorized for Optometrists. Schedule VI includes all prescription drugs not in Schedules II - V.

13) Have you ever been convicted of any violation of State or Federal law relating to the manufacture, possession, distribution or dispensing of controlled substance?
- ☐ Yes*
- ☐ No

14) Has any previous professional license or registration held by you 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 13 or 14, an explanation in writing is required. Please submit a typewritten 8 ½ by 11 sheet(s) with the following information: Complete date and location of each incident, specific charges, disposition(s), copies of court documents, names and addresses of attorneys who represented you and an explanation for each incident or situation. Your name must be on all pages. Your application will NOT be complete until the Drug Control Program has reviewed the documentation and any other required information.*

Attestation

I hereby certify that, under pains and penalties of perjury, all of the information submitted in this application and attachments is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for MCSR revocation or denial of the MCSR and may subject me to civil or criminal penalties. My signature on this MCSR application attests under penalties of perjury that, to the best of my knowledge and belief, I have complied with: state tax and child support laws M.G.L. c. 62C, section 49A); and 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