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 Fax 617-753-8233

Application for Massachusetts Controlled Substances Registration for Pharmacists

Please be sure to:
- Submit completed application, sides 1 and 2.
- Enclose check or money order for $150 made payable to "Commonwealth of Massachusetts".
- Applicant and supervising physician need to sign (not initialed) and date the form.
- Include copies of each supervising physician(s)' Massachusetts Controlled Substances Registration (MCSR) and federal DEA Controlled Substance Registration.
- Incomplete applications will be returned and will cause a delay in receiving your MCSR. Where photocopied licenses and registrations are to be submitted along with your application, do not send originals. They will not be returned.
- For further information, visit: http://www.mass.gov/dph/dcp.

Application Type: (Please select one) ❑ New ❑ Renewal

In the boxes below enter the requested information.

1) Massachusetts Board of Registration License No.:

2) DEA Controlled Substance Registration No. (If possessed):

3) Name:

First: Middle: Last:

Suffix: (e.g. Jr., Sr., II, III)

4) Applicant 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. List every business location where you practice. If you change business addresses during the year, you are required to notify this program by submitting an amended application.

Facility Name and Department (if applicable):

Street:

City: State: ZIP:

5) Business Telephone No.: ( )
area code

6) Social Security No.: (Required by M.G.L. c. 30A, s. 13A)

7) Practice Setting: ❑ Hospital ❑ Long-term Care Facility ❑ Inpatient or Outpatient Hospice
❑ Ambulatory Care Clinic ❑ Community/Retail Pharmacy
(Check all that apply)

8) Drug Schedules requested: (Only Schedules that are checked can be authorized.)

Select all that apply: ❑ II ❑ III ❑ IV ❑ V ❑ VI
A pharmacist practicing in Community/Retail pharmacy may only select Schedule VI.

9) E-mail Address: (Optional)

10) Have you ever been convicted of any violation of State or Federal law relating to the manufacture, possession, distribution or dispensing of controlled substances? ❑ Yes * ❑ No

11) 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 No. 10) or No. 11), a letter must be attached setting forth circumstances of such action(s).

Applicant name: _____

Supervising Physician's Information	
12) The following Supervising Physician's information must be completed for each physician supervising your practice. The supervising physician is the individual with whom you, the applicant, have developed and signed a collaborative practice agreement. If you practice in more than one medical specialty or in more than one setting (e.g., more than one employer), you must complete this section for each supervising physician for each medical specialty and/or setting. You may make photocopies of this page as necessary.	
Name of Supervising Physician:	Telephone No. ( ) area code
Business Address:	
Board of Medicine License No.:	Massachusetts Controlled Substances Registration No.:
DEA Controlled Substance Registration No.:	Medical Specialty:
13) Is there a developed written and signed collaborative practice agreement in place? ❑ Yes ❑ No A written collaborative practice agreement is required for Pharmacist CDTM. Applications not checked Yes will be returned.	
14) Please indicate in which setting the collaborative practice agreement applies: ❑ Hospital ❑ Long-term Care Facility ❑ Inpatient or Outpatient Hospice ❑ Ambulatory Care Clinic ❑ Community/Retail Pharmacy	
Signature of Supervising Physician (no initials): _____ Date _____	

I hereby certify that (1) the information on this application is true to the best of my knowledge; (2) I possess a written collaborative practice agreement that was mutually developed, agreed upon, and signed by my supervising physician and me; (3) I will comply with the laws of the Commonwealth of Massachusetts and all applicable rules and regulations of the Department of Public Health and the Board of Registration in Pharmacy (247 CMR), whichever is applicable; and (4) I will complete, in each year of the term of the agreement, at least 5 additional contact hours or 0.5 continuing education units of Board of Registration in Pharmacy approved continuing education that address areas of practice generally related to the particular collaborative practice agreement. I also certify, in accordance with M.G.L. c. 62C, section 49A, that I have to the best of my knowledge and belief complied with all laws of the commonwealth relating to taxes, reporting of employees and contractors, and withholding and remitting of child support.

Signed under the pains and penalties of perjury.

Signature of applicant (no initials) _____ Date _____

If you have questions, you may call the Drug Control Program at 617-973-0949.

For Office Use Only	
Comments:	Verified supervising physician's current MCSR:
	Application approved by:
	Date: