Commonwealth of Massachusetts
Department of Public Health, Bureau of Health Professions Licensure
Drug Control Program
250 Washington Street, Boston, MA 02108
Telephone 617-973-0949 Fax 617-753-8233

Application for Massachusetts Controlled Substances Registration for Schools

Please be sure to:

- Complete the application form.
- Enclose check or money order for $300 made payable to "Commonwealth of Massachusetts".
- No fee is charged for submitting *Amended Information* form.
- Sign (not initial) and date form.
- Attach a list of all sites (school or building name and address) at which prescription medication(s) will be stored under this registration.

Incomplete applications will be returned and delay issuance of the registration. For further information visit: http://www.mass.gov/dph/dcp.

Application Type: (Please select one) ❑ New ❑ Renewal ❑ Amended Information *(No fee)*

In the boxes below enter the requested information.
1) Applicant: (Name of School or School System **by the** School Committee/Board of Trustees)
2) Applicant Business Address: (A P.O. Box number without a street address cannot be processed.) Street: City: State: ZIP:
3) Applicant Mailing Address (If different than above.): Street: City: State: ZIP:
4) Name of Designated Nurse for School or School System:
5) Deisgnated Nurse's Telephone No.: ( ) area code
6) For renewal applications, enter current MA Controlled Substance Registration No.:

I hereby certify that the information on this application is true to the best of my knowledge, and that the applicant will comply with the laws of the Commonwealth of Massachusetts and all applicable rules and regulations promulgated by the Department of Public Health. I also certify, in accordance with M.G.L. c. 62C, section 49A, that the applicant has 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 authorized individual _____ Date _____
Designated nurse or other authorized individual

Print Name: _____

Title: _____