



**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 to Use Controlled Substances
 and Investigational New Drugs in Research**

Please be sure to:

- Submit completed application – front and back.
- Attach the *Additional Documents Required to be Submitted with Your Application*. See list on page 3.
- Enclose check or money order for \$150 made payable to "Commonwealth of Massachusetts".
- Have the form signed (not initialed) and dated.
- Mail to the address above.

Incomplete applications will be returned causing a delay in issuance of the MCSR. Only send copies of supporting documents. Originals will not be returned. For further information, visit: <http://www.mass.gov/dph/dcp>

Application Type: (Please select one) New Renewal Amended Information

In the boxes below enter the requested information.	
1) Degree:	
2) Board of Registration in Medicine No. (If possessed):	
3) DEA Controlled Substance Registration No. (If possessed):	
4) Name of (Select one): <input type="checkbox"/> Principal investigator <input type="checkbox"/> Department head	
First:	Middle:
Last:	Suffix: (Jr., Sr., II, III)
5a) Address of Company, department, and description of location where drugs will be stored:	5b) Mailing address:
<div style="display: flex; justify-content: space-between;"> City: State: Zip: </div>	<input type="checkbox"/> Same as Company, department, and location where drugs will be stored <input type="checkbox"/> Street: <div style="display: flex; justify-content: space-between;"> City: State: Zip: </div>
Submit a separate application for each location where drugs are stored. If no drugs are being stored, you do not have to register. Registrations are not transferable from one individual to another or from one location to another. Applications with a P.O. Box number and no street address cannot be processed.	
6) Business Telephone No.:	
7) E-mail address:	
8) Social Security No.: (Required by M.G.L. c. 30A, s. 13A)	
9) Select ONLY the drug Schedules currently in use: List the name of EACH specific drug used. Include attachments if more space is needed.	
<input type="checkbox"/> IND _____ <input type="checkbox"/> I _____ <input type="checkbox"/> II _____ <input type="checkbox"/> III _____ <input type="checkbox"/> IV _____ <input type="checkbox"/> V _____ <input type="checkbox"/> VI _____	
(Schedule VI includes all prescription drugs not in Schedules II-V.)	

10) What is the source of the Controlled Substances and/or INDs supplied to/obtained by the researcher?

11) Has the study been approved by an Institutional Review Board (IRB) or Institutional Animal Care and Use Committee (IACUC)? Please attach copy of approval letter. Yes No

12) For what purpose will the Controlled Substances and/or INDs be used? Please be specific.

13) Describe, in detail, the manner in which the Controlled Substances and/or INDs be secured.

Exact location: _____

Construction of storage area: _____

Accountability system: _____

Names of all individuals (including P.I. and sub-investigators) permitted access: _____

14) 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

15) 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. 14) or No. 15), a letter must be attached setting forth circumstances of such action(s).

I hereby certify that the information on this application is true to the best of my knowledge, and that I 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 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 _____

Date _____

Principal Investigator/ Department Head

Print name _____

Additional Documents Required to be Submitted with Your Application:

- Enclose a copy of your current DEA Researcher Registration if applying for Schedules II –V. If a new DEA Researcher Registration application is needed, call the DEA Boston office at 617-557-2200.
- Attach a copy of an IRB or IACUC approval letter for any human/animal research which is not hospital based.
- Attach a copy of an FDA Form 1572 for any human research which is not hospital based and involves investigational new drugs

For Office Use Only	
Application approved by:	Comments:
Date:	