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. All fees are non-refundable and non-transferable.
- Mail your application to:
  Bureau of Health Professions Licensure
  Drug Control Program, Attn: MCSR
  239 Causeway Street, 5th Floor Suite 500
  Boston, MA 02114
- If you wish to apply online and pay by credit, debit, or e-check, visit:
  https://onlineservices.hhs.state.ma.us/
- 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 site address who is responsible for those activities at that site.

Important Information on DEA Number Requirement

- MCSR registrants must have an active DEA number and matching drug schedules within 90 days of receiving their MCSR. After 90 days without an active DEA number, the registrant’s MCSR will be in jeopardy of being dropped to Schedule VI permissions only.
- DEA does not license Schedule VI.
- The Drug Control Program will continue to monitor that registrants have an active DEA license for the same drug schedules.

Important Information for Supervising Physicians and Advanced Practice Providers

- Advanced Practice Providers (PAs, APRNs, CDTM pharmacists) must have a Supervising Physician (not applicable to Certified Nurse Midwives (CNM)) in each of their practice settings.
- Supervising physicians must attest that written prescriptive guidelines are in place with their advanced practice provider(s).
- An advanced practice provider may have multiple supervising physicians, and a supervising physician may supervise multiple advanced practice providers.
- A supervising physician must have an active MCSR.
- If the Supervising Physician’s MCSR expires, the advanced practice provider’s MCSR will automatically be updated to “pending supervisor” status and all prescribing, dispensing, ordering,
storing, and/or administering controlled substances activities must be suspended.

- To minimize the impact on advanced practice providers, 30-60 days before a Supervising Physician’s expiration date, both the Supervising Physician and advanced practice providers will be notified.
- In a scenario where an advanced practice provider has multiple Supervising Physicians and one Supervising Physician’s MCSR expires while all others stay active, the advanced practice provider will receive the aforementioned communications, but will not be updated to “pending supervisor” status.

In the boxes below enter the requested information:

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<td>Personal address, if different than business address provided for the business address:</td>
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<td>MCSR Business Address:</td>
<td>Applications that include a P.O. Box number without a street address cannot be processed. Out-of-state addresses require a letter of explanation. If you change business addresses during the year, you are required to terminate your MCSR and apply for a new MCSR with the new business address.</td>
<td>Facility Name and Department (if applicable):</td>
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<td>Business email address:</td>
<td>Note: You will receive important reminders and notices for your MCSR at this email address.</td>
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<td>Drug Schedules requested: (Only Schedules that are checked can be authorized.)</td>
<td>Select all that apply: □ II □ III □ IV □ V □ VI</td>
<td>A pharmacist practicing in Community/Retail pharmacy may only select Schedule VI.</td>
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Questions 13-22 For APRNs, PAs, CDTMs Only
(Not applicable to CNM)

- Advanced Practice Providers (PAs, APRNs, CDTM pharmacists) must have a Supervising Physician (not applicable to Certified Nurse Midwives (CNM)) in each of their practice settings.
- Supervising physicians must attest that written prescriptive guidelines are in place with their advanced practice provider(s).
- An advanced practice provider may have multiple supervising physicians and a supervising physician may supervise multiple advanced practice providers.
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- In a scenario where an advanced practice provider has multiple Supervising Physicians and one Supervising Physician's MCSR expires while all others stay active, the advanced practice provider will receive the aforementioned communications, but will not be updated to “pending supervisor” status.
- Please photocopy this section of the application should you have more than two Supervising Physicians.

13) Supervising Physician's Name:_______________________________________
14) Board of Medicine License No.:________________________
15) MCSR #:________________________
16) Do you have prescriptive guidelines in place? ___ Y ___ N Written prescriptive guidelines are required for Advanced Practice Provider. Applications checked “No” will be denied.

    By signing below, you are attesting that you are the supervisor of the Advanced Practice Provider and you are acknowledging that you have prescriptive guidelines in place with the Advanced Practice Provider in this application.

17) Signature of Supervising Physician:________________________Date:________________

Additional Supervising Physicians Information (Optional)

18) Supervising Physician’s Name:_______________________________________
19) Board of Medicine License No.:________________________
20) MCSR #:________________________
21) Do you have prescriptive guidelines in place? ___ Y ___ N Written prescriptive guidelines are required for Advanced Practice Provider. Applications checked “No” will be denied.

    By signing below, you are attesting that you are the supervisor of the Advanced Practice Provider and you are acknowledging that you have prescriptive guidelines in place with the Advanced Practice Provider in this application.

22) Signature of Supervising Physician:________________________Date:________________
23) 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

If you answered yes, 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.

24) 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, 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