

APPLICATION FOR REGISTRATION Under the Controlled Substances Act

INSTRUCTIONS

Save time - apply on-line at www.deadiversion.usdoj.gov

- 1. To apply by mail complete this application. Keep a copy for your records.
2. Mail this form to the address provided in Section 7 or use enclosed envelope.
3. The "MAIL-TO ADDRESS" can be different than your "PLACE OF BUSINESS" address.
4. If you have any questions call 800-882-9539 prior to submitting your application.

IMPORTANT: DO NOT SEND THIS APPLICATION AND APPLY ON-LINE.

DEA OFFICIAL USE :

Grid for DEA Official Use

Do you have other DEA registration numbers?

NO YES checkboxes

MAIL-TO ADDRESS

Please print mailing address changes to the right of the address in this box.

FEE FOR THREE (3) YEARS IS \$551

FEE IS NON-REFUNDABLE

SEE SECTION 1

SECTION 1

APPLICANT IDENTIFICATION

Individual Registration

Business Registration

Name 1 (Last Name of individual -OR- Business or Facility Name)

Name 1 input field

Name 2 (First Name and Middle Name of individual - OR- Continuation of business name)

Name 2 input field

PLACE OF BUSINESS Street Address Line 1

PLACE OF BUSINESS Street Address Line 1 input field

PLACE OF BUSINESS Address Line 2

PLACE OF BUSINESS Address Line 2 input field

City

State

Zip Code

City, State, Zip Code input fields

Business Phone Number

Point of Contact

Business Phone Number and Point of Contact input fields

Business Fax Number

Email Address

Business Fax Number and Email Address input fields

DEBT COLLECTION INFORMATION

Social Security Number (if registration is for individual)

Tax Identification Number (if registration is for business)

Mandatory pursuant to Debt Collection Improvements Act

Social Security Number input field

Provide SSN or TIN. See additional information note #3 on page 4.

Tax Identification Number input field

FOR Practitioner or MLP ONLY:

Professional Degree: select from list only

Professional Degree input field

Professional School:

Professional School input field

Year of Graduation:

Year of Graduation input field

National Provider Identification:

National Provider Identification input field

Date of Birth (MM-DD-YYYY):

Date of Birth input field

SECTION 2 BUSINESS ACTIVITY

BUSINESS ACTIVITY

Check one business activity box only

- Central Fill Pharmacy, Retail Pharmacy, Nursing Home, Automated Dispensing System (ADS), Practitioner (DDS, DMD, DO, DPM, DVM, or MD), Practitioner Military (DDS, DMD, DO, DPM, DVM, or MD), Mid-level Practitioner (MLP) (DOM, HMD, MP, ND, NP, OD, PA, or RPH), Euthanasia Technician, Ambulance Service, Animal Shelter, Hospital/Clinic, Teaching Institution

FOR Automated Dispensing System (ADS) ONLY:

DEA Registration # of Retail Pharmacy for this ADS

DEA Registration # input field

An ADS is automatically fee-exempt. Skip Section 6 and Section 7 on page 2. You must attach a notarized affidavit.

SECTION 3 DRUG SCHEDULES

DRUG SCHEDULES

Check all that apply

- Schedule 2 Narcotic, Schedule 2 Non-Narcotic (2N), Schedule 3 Narcotic, Schedule 3 Non-Narcotic (3N), Schedule 4, Schedule 5

Check this box if you require official order forms - for purchase of schedule 2 controlled substances.

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**Drug Enforcement Administration (DEA) Registration Number
DoD Provider Administration Form**

Statement of Understanding

I understand that the DEA number assigned to me is to be used *only* for official duty in the care of DoD beneficiaries and may not be used for any other category of patients. I understand that the number will be used for prescribing and administering only and cannot be used for purchasing or storing of controlled substances. I understand that the DEA number will be voluntarily surrendered upon separation from military service and a separate DEA number is required for work outside of official military duty.

Applicant Name: ●			
Unit/Facility:	NAVAL MEDICAL CENTER		
Unit Address:	620 JOHN PAUL JONES CIRCLE ATTN: MEDICAL STAFF SERVICES PORTSMOUTH VA 23708-2197		
SSN: ●			
State of: ●		Medical/Dental License Number:	
Expiration Date: ●			
Signature: ●			Date: ●

Credentials Authority: Patricia K. Saunders
 Title: Credentials Authority
 Address: 620 John Paul Jones Circle
 Portsmouth, VA 23708-2197

Phone Number (Commercial): (757) 953-7550

Signature of Credentials Authority: _____ Date: _____

Print this form, sign, where necessary and remit to your Credentials Office for review and submission.

DEA Headquarters
 Attn: Registration Section/ODR (Military Rep)
 PO Box 2639
 Springfield, VA 22152-2639

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