

PRACTICE INFORMATION

9. Delaware **Nursing** License No: _____

If you do not already have a Delaware APN license and prescriptive authority, this application will not be processed until the Board of Nursing issues your APN license and approves prescriptive authority.

10. Do you have a Federal DEA number? Yes No If yes, enter number: _____

If you do not have a federal DEA number, you must file for the [federal DEA registration](#) after your Delaware Controlled Substance registration(s) is approved. *Before* prescribing controlled substances in Delaware, you must have *both* your federal DEA registration and Delaware Controlled Substance registration(s).

11. You must have a **separate** Controlled Substance registration and collaborator for **each** individual practice where you will prescribe controlled substances in Delaware. However, the registration for a practice covers all Delaware locations of that practice. Complete the following information about **each** individual practice in Delaware where you will be prescribing controlled substances. Then arrange for your collaborator at **each** practice to sign where shown.

Enclose a Controlled Substance registration fee for *each* practice you list below.

COLLABORATIVE AGREEMENT 1		
Practice Name: _____		
Location Address: _____ <small>(If more than one location, enter main location. <u>No</u> PO Box!)</small>		
_____	DE	_____
<small>City</small>	<small>State</small>	<small>Zip</small>
Business Phone: _____ Email: _____		
A Collaborative Agreement with the applicant has been established. I am aware that this application is for a Delaware Controlled Substance registration, and if approved, the applicant will be able to prescribe drugs in the Schedules checked in Question 2 of this form provided that he/she obtains a DEA number.		
Collaborator Signature: _____		Date: _____
Printed Name: _____		Delaware Professional License No: _____

COLLABORATIVE AGREEMENT 2		
Practice Name: _____		
Location Address: _____ <small>(If more than one location, enter main location. <u>No</u> PO Box!)</small>		
_____	DE	_____
<small>City</small>	<small>State</small>	<small>Zip</small>
Business Phone: _____ Email: _____		
A Collaborative Agreement with the applicant has been established. I am aware that this application is for a Delaware Controlled Substance registration, and if approved, the applicant will be able to prescribe drugs in the Schedules checked in Question 2 of this form provided that he/she obtains a DEA number.		
Collaborator Signature: _____		Date: _____
Printed Name: _____		Delaware Professional License No: _____

If you need more room to list additional Delaware business/practice(s), you may copy this page and enclose it with the application.

DISCLOSURES

- 12. Have you ever been convicted of a felony or misdemeanor under state or federal law relating to the manufacture, distribution or dispensing of controlled substances? Yes No **If yes, attach a letter explaining the circumstances of such action.**
- 13. Have you had any previous registration under the controlled substances act, state or federal, surrendered, revoked, suspended, denied or pending such action? Yes No **If yes, attach a letter explaining the circumstances of such action.**
- 14. Do you intend to routinely dispense controlled substances? Yes No
- 15. Do you intend to store controlled substances for patient administration? Yes No
- 16. If my collaborative agreement terminates, I understand it is my responsibility to notify the Office of Controlled Substances, that my registration is voided and that I must return my certificate to the office. I understand that I must file a new registration application when a new collaborative agreement is established. Yes No

To assure consideration of your registration application, the OCS office must receive all of these items:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded.

Please note: If you do not already have a Delaware APN license and prescriptive authority, the Board of Nursing must issue your APN license and approve prescriptive authority *before* this application for Controlled Substance registration will be processed. Please allow an *additional* 3-4 weeks to receive your Controlled Substance registration. If you already have a Delaware APN and prescriptive authority, allow 3-4 weeks to receive your Controlled Substance registration.

AFFIDAVIT

I hereby certify that the facts stated in this application, including the statements on the attached schedule, are true, complete and correct and that application is made to obtain a biennial registration pursuant to the Uniform Controlled Substances Act.

I agree to abide to the laws of Delaware and the federal government.

Signature of Applicant: _____ **Date:** _____

State of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____

Signature of Notary: _____

My Commission expires: _____

SEAL

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.