



CANNON BUILDING
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DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
OFFICE OF CONTROLLED SUBSTANCES

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

CONTROLLED SUBSTANCES APPLICATION FOR PHYSICIAN'S ASSISTANTS

For Office Use Only:

DE License #

DEA Check

Office Approval

Inspection

Registration #

TYPE OF APPLICATION

1. Show the type of application you are filing (check one):

- I am applying for a new (*initial*) registration. I am *reapplying* for registration.

2. Check the registration schedule(s) you are applying for:

- Schedule II Schedule III Schedule IV Schedule V

IDENTIFYING AND CONTACT INFORMATION

3. Name: _____

4. Have you been issued a U.S. Social Security Number? Yes No

- If Yes, enter your SSN: _____
- If No, you must file a *Request for Exemption from Social Security Number Requirement*.

5. Date of Birth (month/day/year): _____

6. **Location of Practice Address** (No PO Boxes): _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

7. **Mailing Address** (*if different from location*): _____

City: _____ State: _____ Zip Code: _____

8. Delaware Physician Assistant License No: _____

9. Delaware Prescriber ID No (from Board of Medical Practice): RXPA _____

10. Federal DEA No: _____

DISCLOSURES

11. 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.**

12. Have you had any previous registration under the *state or federal* controlled substances act surrendered, revoked, suspended, denied or pending such action? Yes No **If yes, attach a letter explaining the circumstances of such action.**

13. Do you intend to routinely dispense controlled substances? Yes No

14. Do you intend to store controlled substances for patient administration? Yes No

MAIN SUPERVISING PHYSICIAN - This section is to be completed and signed by the *main* Supervising Physician.

15. Enter information about the *main* Supervising Physician. Do not use a post office box address.

Name _____ Specialty _____
Name of Primary Practice _____
Location of Primary Practice _____
City _____ State **DE** Zip _____
State Controlled Substances Number _____ Federal DEA Number _____
Schedules the Physician Assistant is authorized to prescribe II III IV V
Are you delegating authority to request and issue professional controlled legend medication samples? Yes No
Signature of Supervising Physician _____ Date _____

ALTERNATE SUPERVISION – This section is to be completed and signed by all alternate supervising Physicians.

16. Enter information about any *alternate* Supervising Physicians and addresses, if different than above. Attach additional sheets as necessary.

Name _____ Specialty _____
Name of Primary Practice _____
Location of Primary Practice _____
City _____ State **DE** Zip _____
State Controlled Substances Number _____ Federal DEA Number _____
Schedules the Physician Assistant is authorized to prescribe II III IV V
Are you delegating authority to request and issue professional controlled legend medication samples? Yes No
Signature of Supervising Physician _____ Date _____

Name _____ Specialty _____
Name of Primary Practice _____
Location of Primary Practice _____
City _____ State **DE** Zip _____
State Controlled Substances Number _____ Federal DEA Number _____
Schedules the Physician Assistant is authorized to prescribe II III IV V
Are you delegating authority to request and issue professional controlled legend medication samples? Yes No
Signature of Supervising Physician _____ Date _____

Name _____ Specialty _____
Name of Primary Practice _____
Location of Primary Practice _____
City _____ State **DE** Zip _____
State Controlled Substances Number _____ Federal DEA Number _____
Schedules the Physician Assistant is authorized to prescribe II III IV V
Are you delegating authority to request and issue professional controlled legend medication samples? Yes No
Signature of Supervising Physician _____ Date _____

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. The OCS office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is complete, please allow 3-4 weeks to receive your license.

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:** _____

Printed Name: _____

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

Signature of Notary

Notary seal

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