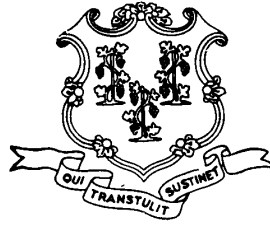


STATE OF CONNECTICUT
 DEPARTMENT OF CONSUMER PROTECTION
 Drug Control Division
 Email: drug.control@ct.gov
 Web Site: www.ct.gov/dcp



For Official Use Only

Controlled Substance Registration for Practitioner

This application must be accompanied by a check or money order in the amount of **\$40.00**, made payable to "**Treasurer, State of Connecticut.**" Upon approval of your application, a registration certificate will be mailed with the effective date of when your application is approved. All registrations expire biennially on February 28th.

→ Return your completed application and fee to:

Department of Consumer Protection, License Services Division, 165 Capitol Avenue, Hartford, CT 06106

First Name		Middle Initial	Last Name		Title
Residence Street Address			City	State	Zip Code
Telephone Number	Social Security Number	Email Address		Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female

Practice Site Name (Physician's Office, Hospital, Long-Term Care Facility, etc.)

Street Address	City	State	Zip Code
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Mailing Address to where all correspondence should be directed: Residence Practice Site Other (as indicated below)

Street Address	City	State	Zip Code
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Professional Medical License Number (from CT Public Health Dept)

Federal DEA Number (if applicable)

Registration Classification: Check (✓) only one

Practitioner Hospital Clinic Resident/Intern Other _____

Drug Schedules:

Schedule I (Research) Schedule II Schedule III Schedule IV Schedule V

Is this application to register as a Medical Director at a Long-Term Care Facility? Yes No

If certified by a specialty board approved by the American Board of Medical Specialties (ABMS), indicate the name of the board and specialty.

American Board Of: _____ Specialty: _____

Has the applicant ever been convicted of any criminal charge under Federal or State controlled drug laws? Yes No If yes, attach a statement of explanation.

Has any Federal or State registration held by the applicant been surrendered, revoked, suspended, limited, denied or is any such action pending? Yes No If yes, attach a statement of explanation.

FOR FEE EXEMPT ONLY: If the applicant is an officer or employee of a Federal, State or Municipal Government agency who is exempt from payment of the registration fee, please complete the following. The registration fee is required if the applicant prescribes, administers or dispenses controlled substances in any capacity not related to his/her Governmental duties. Signature of a supervisor is required for exemption.

Name of Facility or Government Agency: _____

Address: _____

Supervisor's Signature: _____ Title: _____ Date: _____

I have read the above statement and it is true to the best of my knowledge. I fully understand that if I knowingly make a statement that is untrue and which is intended to mislead the Commissioner of Consumer Protection or any person designated by the commissioner in the performance of their official function, I will be in violation of Section 53a-157b of the Connecticut General Statutes.

Signature of Applicant

Date