



CANNON BUILDING
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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

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WEBSITE: WWW.DPR.DELAWARE.GOV

ADVANCED PRACTICE NURSES CONTROLLED SUBSTANCE APPLICATION

(For Office of Controlled Substances Drugs Use Only):

DE License # DEA Check Office Approval Registration #

PLEASE PRINT OR TYPE

New Registration Reapplying Registration – Registration # _____

SECTION A PERSONAL DATA

NAME AND PRACTICE ADDRESS (LAST, FIRST, MIDDLE INITIAL) <i>(Do not use a post office box address)</i>		NAME AND HOME ADDRESS (LAST, FIRST, MIDDLE INITIAL) <i>(Do not use a post office box address)</i>	
DATE OF BIRTH	HOME PHONE	WORK PHONE	
DRIVER LICENSE NUMBER	STATE	SOCIAL SECURITY NUMBER	
ADVANCED PARCTICE NURSE LICENSE NO.		EXPIRATION DATE	
PRESCRIBER I.D. NO.			
RXAPN:		AREA OF SPECIALTY:	
FEDERAL DEA NO.		EMAIL ADDRESS	

SECTION B DISCLOSURES

1. Yes No Has the applicant ever been convicted of a crime in connection with controlled substances under State or Federal law?

2. Yes No Has the applicant ever surrendered or had a Federal controlled substances registration revoked, suspended, restricted, or denied?

3. Yes No Has the applicant ever had a State professional license or controlled substances registration revoked, suspended, denied, restricted, or placed on probation?

4. Yes No If the applicant is a corporation (other than a corporation whose stock is owned and traded by the public), association, partnership, or pharmacy, has any officer, partner, stockholder or proprietor been convicted of a crime in connection with controlled substances under State or Federal law, or ever been suspended, restricted or denied, or ever had a State professional license or controlled substances registration revoked, suspended, denied, restricted, or placed on probation?

* If the answer to any of the above questions is yes, please attach a letter setting forth the circumstances of such action.

SECTION C SCHEDULES REQUESTED

Registration is requested in the following schedules:

II

III

IV

V

SECTION D PRACTICE DATA

*NAME OF COLLABORATOR:

TELEPHONE NUMBER

BUSINESS ADDRESS OF PRACTICE:

A Collaborative Agreement with the applicant has been established. I am aware that this application is for a CSA Number in the State of Delaware, and if approved, the applicant will be able to prescribe drugs in the Schedules checked in Section C of this form provided that he/she obtains a DEA number.

AUTHORIZED SIGNATURE _____ DATE _____

PRINTED NAME _____ LICENSE # _____

If more than one collaborative agreement has been established, please provide same information on additional sheets.

SEE FEE SCHEDULE AT www.dpr.delaware.gov/boards/controlledsubstances FOR FEE AMOUNT.
MAKE CHECKS PAYABLE TO "STATE OF DELAWARE."

SECTION E CERTIFICATION AND NOTARIZATION

I certify that the facts stated in this application are true, complete and correct and that this application is made to obtain biennial registration, pursuant to the Uniform Controlled Substances Act. I will notify the Office of Controlled Substances in writing within 10 days of all changes pertaining to personal data in Section A and practice data in Section D.

SIGNATURE OF APPLICANT

DATE

PRINTED NAME OF APPLICANT

SWORN TO BEFORE ME AND SUBSCRIBED IN MY PRESENCE THIS _____ DAY OF _____, IN THE YEAR OF _____

SIGNATURE OF NOTARY

NOTARY SEAL

APPLICATIONS THAT ARE NOT SIGNED, NOTARIZED OR ACCOMPANIED BY THE REQUIRED FEE WILL BE RETURNED AS INCOMPLETE.