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

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

## APPLICATION FOR CONTROLLED SUBSTANCES REGISTRATION – PHYSICIAN'S ASSISTANTS INSTRUCTION SHEET

### General Information

- **You must hold a Delaware Physician Assistant (PA) license *with prescriptive authority* before your application for controlled substance registration (CSR) will be processed.**
  - If you do not already hold a PA license, use the [Application to Practice as a Physician Assistant](#) to apply.
  - If you already hold a Delaware PA license but you do not yet have prescriptive authority, use the [Physician Assistant Application for Prescriptive Authority](#).
- If you don't already have prescriptive authority when you file this CSR application, you should receive your CSR 3-4 weeks *after* your prescriptive authority is approved. Please allow the 3-4 weeks to elapse before calling the office.
- Your Delaware CSR certificate and all CSR-related correspondence must be mailed to the same address as your PA license.
- You need only one Delaware CSR to **prescribe** controlled substances in Delaware even if you prescribe controlled substances at more than one Delaware business/practice or more than one location of a business/practice. However, every Delaware location where controlled substances are dispensed/stored must be covered by a CSR. If no other practitioner (e.g., physician), physician assistant or APN holds a Delaware CSR for a location where you will **store/dispense**, as well as prescribe, controlled substances, you must file for an additional CSR for the location.
- You must file a [Physician Assistant Application for Prescriptive Authority](#) form to report any new/additional supervising physicians. See **Reporting Supervisory Changes** below.
- When your Delaware CSR is approved, you must then file for a [federal DEA registration](#) for Delaware. **You must have both a Delaware CSR and DEA registration for Delaware before you prescribe controlled substances in Delaware.** A DEA registration in another jurisdiction is not sufficient for prescribing controlled substances in Delaware.

### Requirements for All Applicants

- Submit completed, signed and notarized [Application for Controlled Substances Registration – Physician's Assistants](#).
- Enclose [processing fee](#) by check or money order made payable to "State of Delaware." The fee amount depends on how many controlled substance registrations you are applying for. Multiply the number of registrations applied for by the fee on the Fee Schedule.
- Arrange for your main supervising Physician and for all alternate supervising Physicians to complete and sign the boxes in the SUPERVISION section.
- If you have never been issued a U.S. Social Security Number (SSN), submit a [Request for Exemption from Social Security Number Requirement](#).
  - *The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants:* Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 Del. C. §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 Del. C. §2216) and for other lawful purposes.

### Reporting Supervisory Changes

- If you have only one supervising physician and the supervisory relationship terminates, your CSR becomes null and void. You must notify the Office of Controlled Substances and return your certificate.
- If your supervising physician(s) changes – including new/additional supervisors or departing supervisors – you must file a [Physician Assistant Application for Prescriptive Authority](#) form to report the change. For example, if you already hold a Delaware CSR and you take a second job at another Delaware practice where you will prescribe (but not store/dispense) controlled substances, you must report your supervising physician at the new job even though you do not need another Delaware CSR in this situation.



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**APPLICATION FOR CONTROLLED SUBSTANCES REGISTRATION – PHYSICIAN’S ASSISTANTS**

**For Office Use Only:**

DE License #	DEA Check	Office Approval	Inspection	Registration #
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**TYPE OF APPLICATION**

1. Show the type of Controlled Substance registration (CSR) application you are filing (check all that apply):
    - I am applying for a new (*initial*) CSR. I have never held a Delaware CSR.
    - I am *reapplying* for registration because my former Delaware CSR is lapsed. My previous Delaware CSR number was: \_\_\_\_\_
    - I am applying for a CSR(s) for another location where controlled substances are stored/dispensed **and** no other practitioner (e.g., physician), physician assistant, or APN already holds a Delaware CSR for the location.
  2. How many CSRs are you applying for? \_\_\_\_\_ **Enclose a fee for each CSR.**
  3. Do you already hold a Delaware Physician Assistant license? Yes  No  If yes, enter your license number: **C5** - \_\_\_\_\_
  4. Do you have a Delaware Prescriptive Authority Number (from Board of Medical Licensure and Discipline)?  
Yes  No  If yes, enter license number: RXPA \_\_\_\_\_
- If you do not already hold a Delaware Physician Assistant license with prescriptive authority, allow 3-4 weeks *after* your prescriptive authority is approved to receive your CSR.**
5. Do you already have a federal DEA number? Yes  No  If yes, enter DEA number: \_\_\_\_\_
- When your Delaware CSR is approved, you must then file for a [federal DEA registration](#) for Delaware. You must have both a Delaware CSR and DEA registration for Delaware *before* you prescribe controlled substances in Delaware.**
6. Check the registration schedule(s) you are applying for:
    - Schedule II
    - Schedule III
    - Schedule IV
    - Schedule V

**IDENTIFYING INFORMATION**

7. Name: \_\_\_\_\_
8. Other Names Used: \_\_\_\_\_
9. Date of Birth (month/day/year): \_\_\_\_\_ Gender: Male  Female
10. 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](#).

**PRACTICE INFORMATION**

11. Do you intend to routinely prescribe controlled substances? Yes  No

12. Complete the following information about **each** individual practice in Delaware where you will be prescribing controlled substances. Then arrange for your supervising physician(s) at **each** practice to sign where shown.

**If you need more room to list additional Delaware business/practice(s), provide the same information on a separate sheet and enclose it with the application.**

<b>FIRST PRACTICE</b>		
Business/Practice Name: _____		
<b>Location</b> Address: _____ <small>(If more than one location, enter main location. <u>No PO Box!</u>)</small>		
_____	DE	_____
City	State	Zip
Business Phone: _____ Email: _____		
Will you store or dispense, as well as prescribe, controlled substances at this business/practice? Yes <input type="checkbox"/> No <input type="checkbox"/>		

<b>PRACTICE 2</b>		
Business/Practice Name: _____		
<b>Location</b> Address: _____ <small>(If more than one location, enter main location. <u>No PO Box!</u>)</small>		
_____	DE	_____
City	State	Zip
Business Phone: _____ Email: _____		
Will you store or dispense, as well as prescribe, controlled substances at this business/practice? Yes <input type="checkbox"/> No <input type="checkbox"/>		

<b>PRACTICE 3</b>		
Business/Practice Name: _____		
<b>Location</b> Address: _____ <small>(If more than one location, enter main location. <u>No PO Box!</u>)</small>		
_____	DE	_____
City	State	Zip
Business Phone: _____ Email: _____		
Will you store or dispense, as well as prescribe, controlled substances at this business/practice? Yes <input type="checkbox"/> No <input type="checkbox"/>		

**SUPERVISION – This section is to be completed by your main and all alternate supervising physicians.**

13. Arrange for your main supervising Physician to complete and sign the box below.

<b>MAIN SUPERVISING PHYSICIAN</b>		
Name: _____ Specialty: _____		
Name of Primary Practice: _____		
Location of Primary Practice: _____ <small>Street (No PO Box!)</small>		
_____	DE	_____
City	State	Zip
DE Controlled Substances Registration Number: _____ Federal DEA Number: _____		
Schedules the PA is authorized to prescribe: <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V		
Are you delegating authority to request and issue professional controlled legend medication samples? Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Signature of Supervising Physician</b> _____ Date _____		

14. Do you have any alternate supervising Physicians? Yes  No  If yes, arrange for each alternate supervising Physician to complete and sign one of the boxes below.

**If you need more room, you may copy and enclose this page with your application.**

<b>ALTERNATE SUPERVISING PHYSICIAN</b>			
Name: _____		Specialty: _____	
Name of Primary Practice: _____			
Location of Primary Practice: _____			
Street (No PO Box!)			
_____		DE _____	
City	State	Zip	
DE Controlled Substances Registration Number: _____		Federal DEA Number: _____	
Check the schedules the PA is authorized to prescribe: <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V			
Are you delegating authority to request and issue professional controlled legend medication samples? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>Signature of Supervising Physician</b> _____			Date _____

<b>ALTERNATE SUPERVISING PHYSICIAN</b>			
Name: _____		Specialty: _____	
Name of Primary Practice: _____			
Location of Primary Practice: _____			
Street (No PO Box!)			
_____		DE _____	
City	State	Zip	
DE Controlled Substances Registration Number: _____		Federal DEA Number: _____	
Check the schedules the PA is authorized to prescribe: <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V			
Are you delegating authority to request and issue professional controlled legend medication samples? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>Signature of Supervising Physician</b> _____			Date _____

<b>ALTERNATE SUPERVISING PHYSICIAN</b>			
Name: _____		Specialty: _____	
Name of Primary Practice: _____			
Location of Primary Practice: _____			
Street (No PO Box!)			
_____		DE _____	
City	State	Zip	
DE Controlled Substances Registration Number: _____		Federal DEA Number: _____	
Check the schedules the PA is authorized to prescribe: <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V			
Are you delegating authority to request and issue professional controlled legend medication samples? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>Signature of Supervising Physician</b> _____			Date _____

**DISCLOSURES**

- 15. 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.**
- 16. 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.**

**To assure consideration of your registration application, the Office of Controlled Substances 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 months of filing may be considered abandoned and discarded.**

**Please note: When your application is complete, allow 3-4 weeks to receive your 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:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**State of:** \_\_\_\_\_ **County of:** \_\_\_\_\_

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

**Signature of Notary:** \_\_\_\_\_

SEAL

**My Commission expires:** \_\_\_\_\_

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