Form-224

APPLICATION FOR REGISTRATION
Under the Controlled Substances Act

APPROVED OMB NO 1117-0014
FORM DEA-224 (04-12)
Form Expires: 4/30/2019

INSTRUCTIONS

Save time - apply on-line at *www.deadiversion.usdoj.gov*

1. To apply by mail complete this application. Keep a copy for your records.
2. Mail this form to the address provided in Section 7 or use enclosed envelope.
3. The "MAIL-TO ADDRESS" can be different than your "PLACE OF BUSINESS" address.
4. If you have any questions call 800-882-9539 prior to submitting your application.

IMPORTANT: DO NOT SEND THIS APPLICATION **AND** APPLY ON-LINE.

DEA OFFICIAL USE :

Do you have other DEA registration numbers?

☐ NO ☐ YES

MAIL-TO ADDRESS Please print mailing address changes to the right of the address in this box.

FEE FOR THREE (3) YEARS IS $731
FEE IS NON-REFUNDABLE

SECTION 1 APPLICANT IDENTIFICATION

☐ Individual Registration ☐ Business Registration

Name 1 (Last Name of individual -OR- Business or Facility Name)

Name 2 (First Name and Middle Name of individual - OR- Continuation of business name)

PLACE OF BUSINESS Street Address Line 1

PLACE OF BUSINESS Address Line 2

City State Zip Code

Business Phone Number

Point of Contact: Dora Salazar-James

Business Fax Number

Email Address

DEBT COLLECTION INFORMATION

Mandatory pursuant to Debt Collection Improvements Act

Social Security Number (*if registration is for individual*)

Provide SSN or TIN. See additional information note #3 on page 4.

Tax Identification Number (*if registration is for business*)

FOR Practitioner or MLP ONLY:

Professional Degree : *select from list only*

Professional School :

Year of Graduation :

National Provider Identification:

Date of Birth (*MM-DD-YYYY*): MM-DD-YYYY

SECTION 2 BUSINESS ACTIVITY

Check one business activity box only

☐ Central Fill Pharmacy
☐ Retail Pharmacy
☐ Nursing Home
☐ Automated Dispensing System (ADS)
☐ Practitioner (DDS, DMD, DO, DPM, DVM, or MD)
☐ Practitioner Military (DDS, DMD, DO, DPM, DVM, or MD)
☐ Mid-level Practitioner (MLP) (DOM, HMD, MP, ND, NP, OD, PA, or RPH)
☐ Euthanasia Technician
☐ Ambulance Service
☐ Animal Shelter
☐ Hospital/Clinic
☐ Teaching Institution

FOR Automated Dispensing System (ADS) ONLY:

DEA Registration # of Retail Pharmacy for this ADS

An ADS is automatically fee-exempt. Skip Section 6 and Section 7 on page 2. You must attach a notorized affidavit.

SECTION 3 DRUG SCHEDULES

Check all that apply

☐ Schedule 2 Narcotic
☐ Schedule 2 Non-Narcotic (2N)
☐ Schedule 3 Narcotic
☐ Schedule 3 Non-Narcotic (3N)
☐ Schedule 4
☐ Schedule 5

☐ Check this box if you require official order forms - for purchase of schedule 2 controlled substances.

SECTION 4

STATE LICENSE

MANDATORY

You MUST be currently authorized to prescribe, distribute, dispense, conduct research, or otherwise handle the controlled substances in the schedules for which you are applying under the laws of the **state** or jurisdiction in which you are operating or propose to operate.

State License Number

What state was this license issued in? ______________

Expiration Date ___ / ___ / ______
MM - DD - YYYY

SECTION 5

LIABILITY

IMPORTANT

All questions in this section must be answered.

1. Has the applicant ever been **convicted of a crime** in connection with controlled substance(s) under state or federal law, or been excluded or directed to be excluded from participation in a medicare or state health care program,or is any such action pending? **YES** **NO**

   Date(s) of incident MM-DD-YYYY: __-__-____

2. Has the applicant ever surrendered (for cause) or had a **federal** controlled substance registration revoked, suspended, restricted, or denied, or is any such action pending? **YES** **NO**

   Date(s) of incident MM-DD-YYYY: __-__-____

3. Has the applicant ever surrendered (for cause) or had a **state** professional license or controlled substance registration revoked, suspended, denied, restricted, or placed on probation, or is any such action pending? **YES** **NO**

   Date(s) of incident MM-DD-YYYY: __-__-____

4. 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 substance(s) under state or federal law, or ever surrendered, for cause, or had a **federal** controlled substance registration revoked, suspended, restricted, denied, or ever had a **state** professional license or controlled substance registration revoked, suspended, denied, restricted or placed on probation, or is any such action pending? **YES** **NO**

   Date(s) of incident MM-DD-YYYY: __-__-____ *Note: If question 4 does not apply to you, be sure to mark 'NO'. It will slow down processing of your application if you leave it blank.*

EXPLANATION OF "YES" ANSWERS

Applicants who have answered "YES" to any of the four questions above **must provide a statement to explain each "YES" answer.**

Use this space or attach a separate sheet and return with application

Liability question # ______ Location(s) of incident: ______________

Nature of incident:

Disposition of incident:

SECTION 6 **EXEMPTION FROM APPLICATION FEE**

☐ Check this box if the applicant is a federal, state, or local government official or institution. Does not apply to contractor-operated institutions.

Business or Facility Name of Fee Exempt Institution. **Be sure to enter the address of this exempt institution in Section 1.**

FEE EXEMPT CERTIFIER

Provide the name and phone number of the certifying official

The undersigned hereby certifies that the applicant named hereon is a federal, state or local government official or institution, and is exempt from payment of the application fee.

Signature of certifying official (**other than applicant**) ______________ Date ______

Print or type name and title of certifying official ______________ Telephone No. (**required for verification**) ______

SECTION 7

METHOD OF PAYMENT

Check one form of payment only

☐ Check — **Make check payable to: Drug Enforcement Administration** See page 4 of instructions for important information.

☐ American Express ☐ Discover ☐ Master Card ☐ Visa

Credit Card Number

Expiration Date __ - __

Sign if paying by credit card

Signature of Card Holder ______________

Printed Name of Card Holder ______________

Mail this form with payment to:

DEA Headquarter
ATTN: Registration Section/ODR
P.O. Box 2639
Springfield, VA 22152-2639

FEE IS NON-REFUNDABLE

SECTION 8

APPLICANT'S SIGNATURE

Sign in ink

I certify that the foregoing information furnished on this application is true and correct.

Signature of applicant (sign in ink) ______________ Date ______

Print or type name and title of applicant ______________

WARNING: 21 USC 843(d), states that any person who knowingly or intentionally furnishes false or fraudulent information in the application is subject to a term of imprisonment of not more than 4 years, and a fine under Title 18 of not more than $250,000, or both.

Drug Enforcement Administration (DEA) Registration Number
DoD Provider Multi-Purpose Administrative Form

Statement of Understanding *(Required for New Applications Only)*

I understand that the DEA number assigned to me is to be used only for official duty in the care of DoD beneficiaries and may not be used for any other category of patients, except as allowed by official military duties. I understand that this number will be used for administering, dispensing, or prescribing only and cannot be used for purchasing or storing of controlled substances. I further understand that the DEA number will be voluntarily surrendered upon separation from military service and that a separate DEA number is required for work outside of official military duty.

Applicant Name: ____________________

Unit/Facility: NMC, Portsmouth Medical Staff Services, BLDG 1, 2ND FL, RM C226

Unit Address: 620 John Paul Jones Circle, Portsmouth, VA 23708

Medical/Dental License Number: __________ **State of:** ____ **Expiration Date:** __________

Applicant Signature: ____________________ X **Military** ___ **U.S. Civil Service** ___ **PSC Contractor** (*PSC* Only)

Credentialing Authority Signature: ____________________ **Date:** __________

Typed or Hand-Written Name: Patricia K. Saunders, Department Head, Medical Staff Services

Address: NMC, Portsmouth, Medical Staff Services, BLDG 1,2nd FL, RM C226
620 John Paul Jones Circle, Portsmouth, VA 23708

Phone Number (Commercial): 757-953-7550

Notification of Change of Station *(Upon Military Transfer/Relocation Only)*

Name of Registrant: ____________________

DEA Number of Registrant: ____________________

Old Unit/Facility: NMC, Portsmouth Medical Staff Services, BLDG 1, 2nd FL, RM C226
620 John Paul Jones Circle Portsmouth VA 23708

New Unit/Facility: ____________________

Registrant Signature: ____________________ **Date:** __________

Credentialing Authority Signature: ____________________ **Date:** __________

Typed or Hand-Written Name: Patricia K. Saunders

Phone Number (Commercial): 757-953-7550

Surrender of DEA Registration Certificate *(Upon Separation from Military Service Only)*

I hereby surrender my DEA Registration Certificate. (Please attach certificate)

Name of Registrant: ____________________

Registrant Signature: ____________________ **Date:** __________

Credentialing Authority Signature: ____________________ **Date:** __________

Typed or Hand-Written Name: Patricia K. Saunders

Phone Number (Commercial): 757-953-7550

Mail Completed Form(s) to:
DEA Headquarters
Attn: Registration Section/ODRR - Military POC
8701 Morrissette Drive
Springfield, VA 22152

(Last Revised: 11/08/2013-km)