



**DELAWARE HEALTH
AND SOCIAL SERVICES
DIVISION OF PUBLIC HEALTH
Office of Controlled Substances
Phone 302-744-4547
STATE OF DELAWARE UNIFORM CONTROLLED SUBSTANCES ACT
ACT 16.47 SECTION 4732**

BIENNIAL REGISTRATION/RENEWAL APPLICATION FOR PHYSICIAN ASSISTANTS

(For Office of Controlled Substances Use Only):

_____ License No.	_____ Renewal Date	_____ Amt. Rec'd.	_____ Check No.	_____ Date Rec'd.
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Section A - PERSONAL DATA (Do not use a post office box address)

1. Name and Home Address

2. Date of Birth _____ 3. Phone _____ 4. Work Phone _____ 5. S. S. _____
 6. Driver's License Number _____ State _____
 7. Delaware Physician Assistant License No. _____ Expiration Date _____
 8. Provider I.D. No.: RXPA _____

Section B - DISCLOSURES

- Yes No Has the applicant ever been convicted of a crime in connection with controlled substances under State or Federal law?
- Yes No Has the applicant ever surrendered or had a Federal controlled substances registration revoked, suspended, restricted, or denied?
- Yes No Has the applicant ever had a State professional license or controlled substances registration revoked, suspended, denied, restricted, or placed on probation?
- 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 - PRACTICE DATA (List name, practice location and practice specialty of Supervising Physician(s) - attach additional sheets as necessary. Do not use a post office box address.)

- Primary Practice Location _____
City _____ State _____ Zip _____ Phone _____
- Supervising Physician _____ Specialty _____
- Alternate Supervising Physicians (Address, if different than above)
 - Name _____ Specialty _____ DEA # _____
Address _____ City _____ State _____ Zip _____
 - Name _____ Specialty _____ DEA # _____
Address _____ City _____ State _____ Zip _____
 - Name _____ Specialty _____ DEA # _____
Address _____ City _____ State _____ Zip _____

Section D - PRESCRIPTIVE DATA

The Physician Assistant identified on this form is authorized to prescribe under my supervision the following controlled substances:

1. Supervising Physician(s)

A. Name _____ Schedules _____
Signature _____ Date _____ II III IV V

Physician Assistants may request and issue professional samples of controlled legend medications. Are you delegating this authority? Yes No

State Controlled Substances No. _____ Federal DEA No. _____

B. Name _____ Schedules _____
Signature _____ Date _____ II III IV V

Physician Assistants may request and issue professional samples of controlled legend medications. Are you delegating this authority? Yes No

State Controlled Substances No. _____ Federal DEA No. _____

C. Name _____ Schedules _____
Signature _____ Date _____ II III IV V

Physician Assistants may request and issue professional samples of controlled legend medications. Are you delegating this authority? Yes No

State Controlled Substances No. _____ Federal DEA No. _____

List others on additional page if necessary.

Physician Assistants may request and issue professional samples of controlled legend medications. Are you delegating this authority? Yes No

State Controlled Substances No. _____ Federal DEA No. _____

Section E - CERTIFICATION

By signing this form, the applicant and each Supervising Physician agrees to promptly notify in writing the Board of Medical Practice of all changes (additions or deletions) of Supervising Physicians and of the schedules authorized.

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.

**** Fee: \$40.00 (Make Check Payable to "State of Delaware")

Mail application to:
Office of Controlled Substances
Jesse Cooper Bldg., Room 205
417 Federal Street
Dover, DE 19901

(Signature) _____ (Date)

Name (typed or printed)

FOR STATE USE ONLY:

Approved: _____ P. A. Regulatory Council By: _____
(Date)

Approved: _____ Board of Medical Practice By: _____
(Date)