

Loss of Controlled Substances Report

Article 33 of the New York State Public Health Law requires each incident or alleged incident of theft, loss or possible diversion of controlled substances manufactured, ordered, distributed or possessed by such person, be reported promptly. A copy of the report must be maintained for five years in accordance with Section 3370 of the Public Health Law and Regulation 80.110.

Preferably, this form should be submitted within 1 business day of the incident.

The completed form must be sent to: narcotic@health.ny.gov or faxed to 518-402-0709. Confirmation will be sent.

PLEASE PRINT

BUSINESS INFORMATION			CONTACT INFORMATION	
Business/Licensee Name			Contact Name	
Street			Title	
City	State	Zip	Telephone	
Telephone	County		Fax	
BNE License # (if applicable)			E-Mail	
Business Type <input type="checkbox"/> Pharmacy <input type="checkbox"/> Practice Office <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic <input type="checkbox"/> Nursing Home <input type="checkbox"/> Vet Hospital <input type="checkbox"/> Humane Society <input type="checkbox"/> Manufacturer <input type="checkbox"/> Distributor <input type="checkbox"/> Researcher <input type="checkbox"/> Other _____				

INCIDENT INFORMATION

Check appropriate boxes

Suspected Diversion
 Known Diversion
 Criminal Activity
 Missing
 In-Transit Loss
 Other _____

Date of Incident	Time of Incident	Exact Location Loss or Diversion Occurred (address, room #, floor, etc.)
Law Enforcement Agency Contacted		
Law Enforcement Contact Name		Name of Suspect
Law Enforcement Report #		Suspect Employment Terminated
<input type="checkbox"/> Check if person suspected of diversion or theft is known. Individual's Name: _____ D.O.B: _____ <input type="checkbox"/> Check if person has been terminated. Title: _____ <input type="checkbox"/> Check if person named above is licensed by a state entity. Licensing Entity and #: _____ Address: _____		

In-Transit Losses *Complete this section only if the loss occurred during transit between the sender and receiver.*

Sender's Name			Shipper's Name		
Sender's Address			Shipper's Address		
City	State	Zip	City	State	Zip
Date Sender Notified of Loss			Date Shipper Notified of Loss		
Contact Name and Title			Contact Name and Title		
Contact Telephone Number		Contact Email Address	Contact Telephone Number		Contact Email Address

SUPPORTING DOCUMENTATION

Attach any supportive documentation regarding this incident, i.e. internal investigatory reports, police report, written statements, photographs, videos, recordings, etc.

Loss of Controlled Substances Report

Submission of this form shall not be delayed for internal investigations, etc.

**Describe, in detail, the incident surrounding the lost or stolen controlled substance:
 (Attach additional pages if needed)**

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LOST / STOLEN CONTROLLED SUBSTANCE LISTING

Name of Controlled Substance <i>attach additional forms if needed</i>	NDC # if available	Form	Strength	Quantity

MONETARY VALUE: \$ _____ **TOTAL**

SIGNATURE

I affirm that all information contained on this form is true and correct, to the best of my knowledge, and that I will abide by all laws and regulations pertinent to controlled substances. False statements made herein are punishable as a Class A misdemeanor, pursuant to section 210.45 of the Penal Law.

Name <i>(print)</i>	Title
Signature	Date

Nursing Homes Only: Attorney General's Medicaid Control Fraud Unit Notified? No Yes Date _____

E-mail documents to:
 narcotic@health.ny.gov

Fax documents to:
 518-402-0709

Or mail, only if necessary to:
 Bureau of Narcotic Enforcement
 Riverview Center
 150 Broadway
 Albany, NY 12204

OFFICE USE ONLY
Incident #
CO Reviewed by
Date Referred to Region