

CONTROLLED SUBSTANCE SCHEDULE(S) TO BE UTILIZED (check all that apply) I II III IV V**STORAGE OF CONTROLLED SUBSTANCES** (check all that apply)

<input type="checkbox"/> Vault	Describe
<input type="checkbox"/> Safe	Describe
<input type="checkbox"/> Cabinet	Describe
<input type="checkbox"/> Other	Describe
<input type="checkbox"/> Additional Security	Describe

SUPERVISOR OF CONTROLLED SUBSTANCE ACTIVITY

(complete only if an individual other than the applicant will be supervising controlled substance activity)

Name	Title
Signature	Type of Professional License and Number

APPLICANT ACKNOWLEDGEMENTS

The applicant fully understands that the license to be issued hereon shall be subject to the following stipulations and conditions:

1. The applicant is knowledgeable concerning all laws and regulations, both State and Federal, regarding the licensed activity and shall comply with such requirements.
2. The licensee shall be under a continuing duty to inform the Department of Health of any changes, such as name, address or any substantial change to the physical security and means of record keeping regarding the controlled substance(s).
3. The license privilege herein applied for, if granted, shall not be transferred. Changes in name or ownership of institutional and business licensees shall be immediately reported to the Department of Health.
4. Any license so issued as a result of the application for license shall be promptly returned to the Department of Health upon revocation or suspension of the license or the Federal license for the activity. The license shall be promptly returned to the Department of Health when the activity for which the applicant is licensed has been discontinued.
5. Licensee shall promptly report to the Department of Health each incident or alleged incident of theft, loss or possible diversion of either controlled substances or Official New York State Prescriptions. Such notification shall be by first contacting the local Regional Office of the Department of Health's Bureau of Narcotic Enforcement and then shall be reported on the applicable Department of Health forms. **Reporting of such incident to other government agencies does not relieve the applicant of this responsibility.**

Has the applicant ever been convicted of a felony or crime connected with controlled substances?

 Yes No

Has the applicant ever had a State or Federal professional license or controlled substance license/ registration revoked, suspended, denied or restricted; or has the applicant ever been placed on probation?

 Yes No*If the applicant is a partnership, stockholder, proprietor or corporation (other than a corporation whose stock is owned and traded by the public):* Has any officer been convicted of a felony or crime involving controlled substances under State or Federal law? Has a State or Federal professional license or controlled substance license/registration been revoked, suspended, denied or restricted? Has the applicant ever been placed on probation? Yes No

Applicants who answer "Yes" to any of the above questions must submit a statement of explanation with documentation to support the explanation.

APPLICANT SIGNATURE (must be an original signature in ink)**Under the penalties of perjury, I affirm that the statements herein are true and that I have become knowledgeable regarding the requirements of the licensed activity for which I am applying.**

Name	Title
Signature of Applicant (or Authorized Representative)	Date

Please return your completed application, along with the requisite fee (if applicable) in the form of a check or money order made payable to the New York State Department of Health, Bureau of Narcotic Enforcement, as well as any other documentation required, addressed to:

**New York State Department of Health
Bureau of Narcotic Enforcement
433 River Street, Suite 303
Troy, New York 12180-2299**