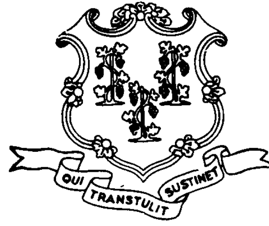
CONTROLLED SUBSTANCE REGISTRATION

The State of Connecticut has a statutory requirement that any prescribing practitioner authorized in their professional practice act to prescribe, administer and dispense controlled drugs must obtain a Connecticut Controlled Substance Registration. This registration is a prerequisite for the Federal Drug Enforcement Administration registration and may be obtained from the Connecticut Department of Consumer Protection.

Instructions for completing CSR:

- Please scroll down and complete the highlighted sections only. You will need to print the form, sign it (do not type your name), and e-mail the form back with your other documents to jgoldsmith@uchc.edu.
- Do not include a check. The Capital Area Health Consortium (CAHC) will pay the initial $40 registration fee. Renewals will be your responsibility but reimbursed by the CAHC.
- Do not mail the form to Department of Consumer Protection.

STATE OF CONNECTICUT
DEPARTMENT OF CONSUMER PROTECTION
Drug Control Division
Email: drug.control@ct.gov
Web Site: www.ct.gov/dcp



For Official Use Only

Controlled Substance Registration for Practitioner

This application must be accompanied by a check or money order in the amount of **$40.00**, made payable to ***"Treasurer, State of Connecticut."*** Upon approval of your application, a registration certificate will be mailed with the effective date of when your application is approved. All registrations expire biennially on February 28th.

➔ Return your completed application and fee to:

Department of Consumer Protection, License Services Division, 165 Capitol Avenue, Hartford, CT 06106

First Name	Middle Initial	Last Name	Title
Residence Street Address		City	State / Zip Code
Telephone Number / Social Security Number	Email Address	Date of Birth	☐ Male ☐ Female

Practice Site Name (Physician's Office, Hospital, Long-Term Care Facility, etc.)			
Street Address	City	State	Zip Code

Mailing Address to where all correspondence should be directed: ☐ Residence ☐ Practice Site ☐ Other (as indicated below)			
Street Address	City	State	Zip Code

Professional Medical License Number (from CT Public Health Dept)	Federal DEA Number (if applicable)

Registration Classification: Check (✓) only one

☐ Practitioner ☐ Hospital ☐ Clinic ☐ Resident/Intern ☐ Other ________________

Drug Schedules:

☐ *Schedule I (Research)* ☐ Schedule II ☐ Schedule III ☐ Schedule IV ☐ Schedule V

Is this application to register as a Medical Director at a Long-Term Care Facility? ☐ Yes ☐ No

If certified by a specialty board approved by the American Board of Medical Specialties (ABMS), indicate the name of the board and specialty.

American Board Of: ________________ Specialty: ________________

Has the applicant ever been convicted of any criminal charge under Federal or State controlled drug laws? ☐ Yes ☐ No If yes, attach a statement of explanation.

Has any Federal or State registration held by the applicant been surrendered, revoked, suspended, limited, denied or is any such action pending?
☐ Yes ☐ No If yes, attach a statement of explanation.

FOR FEE EXEMPT ONLY: If the applicant is an officer or employee of a Federal, State or Municipal Government agency who is exempt from payment of the registration fee, please complete the following. The registration fee is required if the applicant prescribes, administers or dispenses controlled substances in any capacity not related to his/her Governmental duties. Signature of a supervisor is required for exemption.

Name of Facility or Government Agency: ________________

Address: ________________

Supervisor's Signature: ________________ Title: ____________ Date: ____________

I have read the above statement and it is true to the best of my knowledge. I fully understand that if I knowingly make a statement that is untrue and which is intended to mislead the Commissioner of Consumer Protection or any person designated by the commissioner in the performance of their official function, I will be in violation of Section 53a-157b of the Connecticut General Statutes.

________________________________ ________________

Signature of Applicant Date