

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE - PUBLIC HEALTH SERVICES

OFFICE OF CONTROLLED SUBSTANCES ADMINISTRATION (OCSA) *formerly Division of Drug Control*

4201 Patterson Avenue – 5th Fl., Baltimore, Maryland 21215

OCSA Website: <http://dhmh.maryland.gov/ocsa> ■ OCSA Email: Maryland.OCSA@Maryland.Gov

Main Office: (410) 764-2890 ■ Fax: (410) 358-1793 ■ Customer Service: (410) 764-5910, (410) 764-7980, (410) 764-4159

(Revised: 1/18/17)



ESTABLISHMENT APPLICATION	3-YEAR CDS REGISTRATION APPLICATION	CDS #:
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FOR OFFICE USE ONLY: APPLICATION AUDIT CONTROL SECTION	Processor Initials: _____ Date: ____/____/____ Note:
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Do Not Write In This Section.

SEE INSTRUCTIONS ATTACHED. COMPLETE SECTIONS 1, 2 AND 3 BELOW. SIGN, DATE APPLICATION AND INCLUDE PAYMENT. APPLICATIONS TORN IN HALF, INCOMPLETE OR WITHOUT PAYMENTS WILL BE RETURNED, WHICH DELAYS PROCESSING. REQUIRED: UPDATED ESTABLISHMENT QUESTIONNAIRE (EQ) OR COPY OF APPROPRIATE LICENSE (L) AND EMAIL ADDRESS FOR RENEWAL NOTIFICATION. * **KEEP A COPY OF APPLICATION.**

SECTION 1: APPLICATION CLASSIFICATION, TYPE, PAYMENT AND FEE EXEMPT DETAILS

A. CLASSIFICATION - Check only one box . For lawful registration, separate application required for each Establishment Classification.

<input type="checkbox"/> Automatic Dispensing Systems (II-V) (L) <input type="checkbox"/> Animal Control Facility (II-III) (L) <input type="checkbox"/> Assisted Living Facility (II-V) (L) <input type="checkbox"/> Clinics (II-V) (L) (EQ) <input type="checkbox"/> Drug/Alcohol Programs (II-V) (L) <input type="checkbox"/> Hospital (Human/Animal) (II-V) (L) <input type="checkbox"/> Long Term Care (II-V) (L) <input type="checkbox"/> Methadone (II-V) (L) <input type="checkbox"/> Pharmacy (II-V) (L) <input type="checkbox"/> Non Resident Pharmacy (II-V) (EQ)	Check which Schedules Apply: <table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td align="center">I</td> <td align="center">II</td> <td align="center">III</td> <td align="center">IV</td> <td align="center">V</td> </tr> <tr> <td><input type="checkbox"/> Distributor (L) (EQ)</td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Exporter (L) (EQ)</td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Importer (L) (EQ)</td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Manufacturer (L) (EQ)</td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Laboratory-Analytical (EQ)</td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Law Enforcement Agency-K-9(EQ)</td> <td align="center"><input type="checkbox"/></td> </tr> </table>		I	II	III	IV	V	<input type="checkbox"/> Distributor (L) (EQ)	<input type="checkbox"/> Exporter (L) (EQ)	<input type="checkbox"/> Importer (L) (EQ)	<input type="checkbox"/> Manufacturer (L) (EQ)	<input type="checkbox"/> Laboratory-Analytical (EQ)	<input type="checkbox"/> Law Enforcement Agency-K-9(EQ)	<input type="checkbox"/>																													
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B. FEE PAYMENT DETAILS	FOR OFFICE USE ONLY	C. FEE EXEMPT DETAILS FOR GOVERNMENT AGENCIES
(Fee Payable to DHMH-OCSA/ formerly Drug Control)	App. Receive Date: / /	CHECK TYPE: <input type="checkbox"/> State <input type="checkbox"/> Local (Agency Unit Code):
TYPE	Deposit Date: / /	Agency/Institution Name
Renewal**	<input type="checkbox"/> \$120	Check/Mo #:
New	<input type="checkbox"/> \$120	Processor Initials:
Address Change Only	<input type="checkbox"/> \$50	Do Not Write In This Section.
Name Change Only	<input type="checkbox"/> \$50	
Duplicate CDS Permit	<input type="checkbox"/> \$30	
Change of Ownership	<input type="checkbox"/> \$144	
Closing	<input type="checkbox"/> \$0	
(Fees are Non-Refundable.) **No additional fee for Name or Address change at time of renewal.		Agency/Institution Business Address
		Contact Telephone #
		Print Certifier Name
		Date: / /
		(Signature of Certifier)

SECTION 2: APPLICANT DETAILS

SECTION 3: PROFESSIONAL LICENSE DETAILS

A. Establishment Name/DBA		A. Health Occupational Board, OHCQ, Other License #:	Expiration Date: / /
		B. Federal DEA #:	Expiration Date: / /
		C. Tax ID Number:	
B. Responsible Person Name (print) (First) (Middle) (Last)		D. Has your federal, State or Health Occupational license ever been denied, suspended, restricted, revoked, reprimanded, or placed on probation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
C. Title		E. Has the responsible person ever been convicted of a violation of law pertaining to CDS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
D. Business Address City/State/Zip County		F. Have restrictions been placed on the entity's handling of CDS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
E. Mailing Address City/State/Zip (If different than D)		If yes is the answer to any of the above questions, submit a detailed explanation and copies of pertinent/supporting documentation.	
F. Telephone Nos.	Business No.: Fax No. (Required): Alternate or Cell No.:	H. If you are a pharmacy that dispenses CDS, are you Reporting to the Prescription Drug Monitoring Program? <input type="checkbox"/> Yes <input type="checkbox"/> No For more details, go to the PDMP website at http://bha.dhmh.maryland.gov/PDMP .	
G. Email* (Required)		SIGNATURE OF RESPONSIBLE PERSON:	DATE: / /

Your signature attests to the fact that the information provided is accurate. It is the sole and continuing responsibility of the CDS Registrant to ensure the Office of Controlled Substances Administration (OCSA) has the correct and current address information on file for the issued CDS Registration.