



For Official Use Only

**STATE OF CONNECTICUT
DEPARTMENT OF CONSUMER PROTECTION**

Drug Control Division (860) 713-6065

Web Site: www.state.ct.us/dcp/

CONTROLLED SUBSTANCE REGISTRATION FOR PRACTITIONERS

➔ **Return completed application and fee to:**

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

Fee Due: \$ 10.00

➔**Note:** Upon approval of this application a registration will be sent to you. Your effective date will be the date your application is approved. **All registrations expire annually on February 28th.**

Make check payable to:
"Treasurer, State of CT"

Name (First Name, Middle Initial, Last Name)			Title	
Street Address		City	State	Zip Code
Telephone Number (w/ area code)	Date of Birth	Social Security Number	Email Address	
Professional License Number (From State Public Health Dept)		Federal DEA Number (From Federal Drug Enforcement Admin)		
Registration Classification: (Check one (1) only)				
Practitioner	Hospital	Clinic	Resident	Intern
Other (Specify) _____				
Drug Schedules:	Schedule II	Schedule III	Schedule IV	Schedule V
Schedule I (Research)				
Is the applicant currently authorized to prescribe, administer, dispense, or otherwise handle controlled substances in schedules checked below under Connecticut state law? Yes No				
Has the applicant ever been convicted of any criminal charge under Federal or State controlled drug laws? Yes No <i>If yes, complete the Letter of Explanation on the back of this form</i>				
Has any Federal or State registration held by the applicant been surrendered, revoked, suspended, limited, denied or is any such action pending? Yes No <i>If yes, complete the Letter of Explanation on the back of this form</i>				

Is the applicant an officer or employee of a Federal, State or Municipal Government agency who is exempt from payment of registration fee? Yes No

If **YES**, complete the following:
FOR FEE EXEMPT ONLY:

Note: Registration fee is required with this application 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: _____

I certify that the information contained in this application is the truth to the best of my knowledge.

Signature of Applicant _____ Date _____

