Form-224

APPLICATION FOR REGISTRATION
Under the Controlled Substances Act

APPROVED OMB NO 1117-0014
FORM DEA-224 (07-11)
Previous editions are obsolete

INSTRUCTIONS

Save time - apply on-line at *www.deadiversion.usdoj.gov*

1. To apply by mail complete this application. Keep a copy for your records.
2. Mail this form to the address provided in Section 7 or use enclosed envelope.
3. The "MAIL-TO ADDRESS" can be different than your "PLACE OF BUSINESS" address.
4. If you have any questions call 800-882-9539 prior to submitting your application.

IMPORTANT: DO NOT SEND THIS APPLICATION **AND** APPLY ON-LINE.

X DEA OFFICIAL USE :

Do you have other DEA registration numbers?

☐ NO ☐ YES

MAIL-TO ADDRESS Please print mailing address changes to the right of the address in this box.

SEE SECTION 1

FEE FOR THREE (3) YEARS IS $551
FEE IS NON-REFUNDABLE

SECTION 1 APPLICANT IDENTIFICATIION

☒ **Individual Registration** ☐ **Business Registration**

Name 1 (Last Name of individual -OR- Business or Facility Name)

Name 2 (First Name and Middle Name of individual - OR- Continuation of business name)

PLACE OF BUSINESS Street Address Line 1

PLACE OF BUSINESS Address Line 2

City | State | Zip Code

Business Phone Number | Point of Contact

Business Fax Number | Email Address

X **DEBT COLLECTION INFORMATION**

Mandatory pursuant to Debt Collection Improvements Act

Social Security Number (***if registration is for individual***) *

Provide SSN or TIN. See additional information note #3 on page 4.

Tax Identification Number (***if registration is for business***)

X **FOR Practitioner or MLP ONLY:**

Professional Degree : *select from list only*

Professional School :

Year of Graduation :

National Provider Identification:

Date of Birth (*MM-DD-YYYY*): M M D D Y Y Y Y

X SECTION 2 BUSINESS ACTIVITY

Check one business activity box only

- ☐ Central Fill Pharmacy
- ☐ Retail Pharmacy
- ☐ Nursing Home
- ☐ Automated Dispensing System (ADS)
- X ☐ Practitioner (DDS, DMD, DO, DPM, DVM, or MD)
- ☐ Practitioner Military (DDS, DMD, DO, DPM, DVM, or MD)
- ☐ Mid-level Practitioner (MLP) (DOM, HMD, MP, ND, NP, OD, PA, or RPH)
- ☐ Euthanasia Technician
- ☐ Ambulance Service
- ☐ Animal Shelter
- ☐ Hospital/Clinic
- ☐ Teaching Institution

FOR Automated Dispensing System (ADS) ONLY:

DEA Registration # of Retail Pharmacy for this ADS

An ADS is automatically fee-exempt. Skip Section 6 and Section 7 on page 2. You must attach a notorized affidavit.

X SECTION 3 DRUG SCHEDULES

Check all that apply

- ☐ Schedule 2 Narcotic
- ☐ Schedule 2 Non-Narcotic (2N)
- ☐ Schedule 3 Narcotic
- ☐ Schedule 3 Non-Narcotic (3N)
- ☐ Schedule 4
- ☐ Schedule 5

☐ Check this box if you require official order forms - for purchase of schedule 2 controlled substances.

X SECTION 4

STATE LICENSE

You MUST be currently authorized to prescribe, distribute, dispense, conduct research, or otherwise handle the controlled substances in the schedules for which you are applying under the laws of the **state** or jurisdiction in which you are operating or propose to operate.

MANDATORY * State License Number

* What state was this license issued in? _____

Expiration Date / / _____
MM - DD - YYYY

X SECTION 5

LIABILITY

IMPORTANT

All questions in this section must be answered.

	YES	NO
1. Has the applicant ever been **convicted of a crime** in connection with controlled substance(s) under state or federal law, or been excluded or directed to be excluded from participation in a medicare or state health care program,or is any such action pending?	☐	☐
Date(s) of incident MM-DD-YYYY: ☐☐-☐☐-☐☐☐☐		
2. Has the applicant ever surrendered (for cause) or had a **federal** controlled substance registration revoked, suspended, restricted, or denied, or is any such action pending?	☐	☐
Date(s) of incident MM-DD-YYYY: ☐☐-☐☐-☐☐☐☐		
3. Has the applicant ever surrendered (for cause) or had a **state** professional license or controlled substance registration revoked, suspended, denied, restricted, or placed on probation, or is any such action pending?	☐	☐
Date(s) of incident MM-DD-YYYY: ☐☐-☐☐-☐☐☐☐		
4. If the applicant is a **corporation** (other than a corporation whose stock is owned and traded by the public), association, partnership, or pharmacy, has any officer, partner, stockholder, or proprietor been c**onvicted of a crime** in connection with controlled substance(s) under state or federal law, or ever surrendered, for cause, or had a **federal** controlled substance registration revoked, suspended, restricted, denied, or ever had a **state** professional license or controlled substance registration revoked, suspended, denied, restricted or placed on probation, or is any such action pending?	☐	☐
Date(s) of incident MM-DD-YYYY: ☐☐-☐☐-☐☐☐☐		

Note: If question 4 does not apply to you, be sure to mark 'NO'. It will slow down processing of your application if you leave it blank.

X EXPLANATION OF "YES" ANSWERS

Applicants who have answered "YES" to any of the four questions above **must provide a statement to explain each "YES" answer.**

Use this space or attach a separate sheet and return with application

Liability question # _____ Location(s) of incident: _____

Nature of incident:

Disposition of incident:

SECTION 6 EXEMPTION FROM APPLICATION FEE

☒ X Check this box if the applicant is a federal, state, or local government official or institution. Does not apply to contractor-operated institutions.

Business or Facility Name of Fee Exempt Institution. **Be sure to enter the address of this exempt institution in Section 1.**

The undersigned hereby certifies that the applicant named hereon is a federal, state or local government official or institution, and is exempt from payment of the application fee.

FEE EXEMPT CERTIFIER

Provide the name and phone number of the certifying official

Signature of certifying official (**other than applicant**) _____ Date _____

Print or type name and title of certifying official _____ Telephone No. (required for verification) _____

SECTION 7

METHOD OF PAYMENT

Check one form of payment only

☐ Check Make check payable to: **Drug Enforcement Administration**
See page 4 of instructions for important information.

☐ American Express ☐ Discover ☐ Master Card ☐ Visa

Credit Card Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiration Date ☐☐ - ☐☐

Sign if paying by credit card

Signature of Card Holder _____

Printed Name of Card Holder _____

Mail this form with payment to:

DEA Headquarter
ATTN: Registration Section/ODR
P.O. Box 2639
Springfield, VA 22152-2639

FEE IS NON-REFUNDABLE

X SECTION 8

APPLICANT'S SIGNATURE

Sign in ink *

I certify that the foregoing information furnished on this application is true and correct.

Signature of applicant (sign in ink) _____ Date _____

Print or type name and title of applicant _____

WARNING: 21 USC 843(d), states that any person who knowingly or intentionally furnishes false or fraudulent information in the application is subject to a term of imprisonment of not more than 4 years, and a fine under Title 18 of not more than $250,000, or both.

****** For Official Use Only (FOUO) ******

Drug Enforcement Adminstration (DEA) Registration Number
DoD Provider Adminstration Form

Statement of Understanding

I understand that the DEA number assigned to me is to be used *only* for official duty in the care of DoD beneficiaries and may not be used for any other category of patients. I understand that the number will be used for prescribing and administering only and cannot be used for purchasing or storing of controlled substances. I understand that the DEA number will be voluntarily surrendered upon separation from military service and a separate DEA number is required for work outside of official military duty.

Applicant Name: ●			
Unit/Facility:	NAVAL MEDICAL CENTER		
Unit Address:	620 JOHN PAUL JONES CIRCLE ATTN: MEDICAL STAFF SERVICES PORTSMOUTH VA 23708-2197		
SSN:●			
State of:●		Medical/Dental License Number:	
Expiration Date:●			
Signature:●		Date:●	

Credentials Authority:
Title:
Address:

Patricia K. Saunders
Credentials Authority
620 John Paul Jones Circle
Portsmouth, VA 23708-2197

Phone Number (Commercial):

(757) 953-7550

Signature of Credentials Authority: _____ Date: _____

Print this form, sign, where necessary and remit to your Credentials Office for review and submission.

DEA Headquarters
Attn: Registration Section/ODR (Military Rep)
PO Box 2639
Springfield, VA 22152-2639