Commonwealth of Massachusetts, Department of Public Health, Drug Control Program
99 Chauncy Street, Boston, MA 02111
Telephone 617 983-6700 Fax 617 753-8233

Application for Massachusetts Controlled Substances Registration to Use Controlled Substances and Investigational New Drugs in Research in Accordance with the Controlled Substances Act, M.G.L. Chapter 94C

Please be sure to:

- Complete information on both sides of application.
- *Additional Documents Required to be Submitted with Your Application* are listed at the end of the next page.
- Enclose check or money order for $150 made payable to "Commonwealth of Massachusetts".
- Sign and date the form.
- Mail to the address above.

Incomplete applications will be returned and will cause a delay in receiving your Massachusetts Controlled Substances Registration (MCSR). Do not send originals of supporting documents. They will not be returned.
For further information visit our Web site at http://www.mass.gov/dph/dcp

Application Type: (Please select one) ❑ New ❑ Renewal ❑ Amended Information

In the boxes below enter the requested information.
1) Degree:
2) Board of Registration in Medicine No. (If possessed):
3) DEA Controlled Substance Registration No. (If possessed):
4) Name of (Select one): ❑ Principal investigator ❑ Department head First: Middle: Last: Suffix: (Jr., Sr., II, III)
5) Company, department, and location where drugs will be stored: (Submit a separate application for each location where drugs are stored. If no drugs are being stored, you do not have to register. Registrations are not transferable from one individual to another or from one location to another. Applications that include a P.O. Box number without a street address cannot be processed.) City State ZIP
6) Mailing address (If different from Company, department, and location where drugs will be stored) : City State ZIP
7) Business Telephone No.:
8) Social Security No.: (Required by M.G.L. c. 30A, s. 13A)
9) E-mail address: (Optional)

10) Select ONLY the drug Schedules currently in use:
List the name of EACH specific drug used. Include attachments if more space is needed.

- ❑ IND _____
- ❑ I _____
- ❑ II _____
- ❑ III _____
- ❑ IV _____
- ❑ V _____
- ❑ VI _____

(Schedule VI includes all prescription drugs not in Schedules II-V.)

11) From what source are Controlled Substances and/or INDs supplied to the researcher?

_____

_____

12) Has the study been approved by an Institutional Review Board (IRB) or Institutional Animal Care and Use Committee (IACUC)? Please attach copy of approval letter. ❑ Yes ❑ No

13) For what purpose will the Controlled Substances and/or INDs be used? Please be specific.

_____

_____

_____

14) In what manner will the Controlled Substances and/or INDs be secured? Please describe in detail:

_____

Exact location: _____

_____

Construction of storage area: _____

_____

Accountability system: _____

_____

Names of all individuals permitted access: _____

_____

Please include P.I. and subinvestigators.

15) Have you ever been convicted of any violation of State or Federal law relating to the manufacture, possession, distribution or dispensing of controlled substances? ❑ Yes * ❑ No

16) Has any previous professional license or registration held by you under any name or corporate name or legal entity been surrendered, revoked, suspended or denied or is such action pending? ❑ Yes * ❑ No

* If you answered "Yes" to Question No. 15) or No. 16), a letter must be attached setting forth circumstances of such action(s).

I hereby certify that the information on this application is true to the best of my knowledge, and that I will comply with the laws of the Commonwealth of Massachusetts and all applicable rules and regulations promulgated by the Department of Public Health. I also certify, in accordance with M.G.L. c. 62C, s. 49A, that I have to the best of my knowledge and belief filed all state tax returns and paid all state taxes required under law.

Signed under the pains and penalties of perjury.

Signature of applicant (no initials) _____ Date _____

Print name _____

Additional Documents Required to be Submitted with Your Application

- Enclose a copy of your current DEA Researcher Registration if any. If a new application, call the DEA at 617-557-2200 to request an application
- Attach a copy of an IRB or IACUC approval letter for any human/animal research which is not hospital based.
- Attach a copy of an FDA Form 1572 for any human research which is not hospital based and involves investigational new drugs

For Office Use Only	
Application approved by:	Comments:
Date:	