



**Missouri Department of Health and Senior Services**

P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400  
RELAY MISSOURI for Hearing and Speech Impaired 1-800-735-2966

FAX: 573-751-6010  
VOICE: 1-800-735-2466



Dear Applicant:

Attached is an application and instructions to complete an application for a Missouri Controlled Substances Registration. Please review the instructions before completing and submitting the application.

**General Information For All Applications:**

- (1) No controlled substance activities may take place until an application has been processed and a registration has been issued. There are no renewals. All registrations have an expiration date or may terminate under certain conditions. No controlled substance activities may take place until a new registration has been issued. Only the doctor may complete the application and it cannot be delegated.
- (2) A state registration from the Bureau of Narcotics and Dangerous Drugs is required prior to applying for a federal registration from the United States Drug Enforcement Administration. Controlled substance activities may begin once both registrations are in place. LTCFs are not required to have DEA numbers. The addresses on state and federal registrations must match.
- (3) Pursuant to state regulations, all fees are processing fees and are not refundable.
- (4) Checks should be made payable to the Missouri Department of Health and Senior Services.
- (5) Applications and fees are processed through the department's fee receipt unit before being forwarded to the Bureau of Narcotics and Dangerous Drugs for processing and issuing registrations. Applications go to the Fee Receipt Unit before being forwarded to the BNDD.
- (6) The bureau no longer prints and mails controlled substance registration certificates. The verifying and printing of registration certificates can be accomplished at the bureau's website [www.health.mo.gov/BNDD](http://www.health.mo.gov/BNDD).
- (7) Please review your application for completeness and accuracy before submitting it to the department. Errors and omissions cause delays in processing applications. Please insure printing is legible.
- (8) All applications submitted on paper must be mailed to the department's Fee Receipt Unit at the following addresses:

Fee Receipt Unit  
P.O. Box 570  
Jefferson City, MO 65102-0570

Hand delivery address is:  
920 Wildwood Drive  
Jefferson City, MO 65109

Bureau of Narcotics and Dangerous Drugs  
P.O. Box 570  
Jefferson City, MO 65102-0570  
Phone: (573) 751-6321 Fax: (573) 526-2569  
Website [www.health.mo.gov/BNDD](http://www.health.mo.gov/BNDD)

[www.health.mo.gov](http://www.health.mo.gov)

**Healthy Missourians for life.**

The Missouri Department of Health and Senior Services will be the leader in promoting, protecting and partnering for health.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER: Services provided on a nondiscriminatory basis.

## INSTRUCTIONS FOR COMPLETING DENTAL APPLICATION

Please review these instructions and instructional fields as the application is completed to insure all fields are completed correctly with the required information. Incomplete applications cause delays in processing.

Fields on the application that are required to obtain a controlled substances registration are marked with an asterisk(\*). There are other questions on the application that are voluntary for the purposes of taking a census to determine practitioner availability and shortage areas in Missouri.

- (1)\* Indicate if this is your first registration ever, or if you have been registered in Missouri before. All registrations are new and there are no renewals.
- (2)\* A social security number is required pursuant to Section 454.403, RSMo. Applicants must also submit their date of birth MM/DD/YYYY.
- (3)\* Please indicate if you are licensed as a DDS or DMD, or if your state license is currently pending. Licenses are not required for dental students enrolled in an authorized dental school.
- (4)\* Please provide your full legal name, along with your gender, race, and ethnicity.
- (5) Please indicate what languages you fluently speak.
- (6) Please provide your current email address where the bureau may contact you or send information.
- (7)\* Please provide information pertaining to board certifications.
- (8)\* Please check the box to indicate your primary specialty.
- (9)\* Please provide your current DEA controlled substance registration number if you have one. If you do not have one, you may enter the word "pending."
- (10)\* Please indicate what drug schedules you are requesting authority in. A complete list may be viewed at the bureau's website, [www.health.mo.gov/BNDD](http://www.health.mo.gov/BNDD) under the link to publications.
- (11)\* Please indicate what your anticipated drug activity will be at this primary practice location.
- (12)\* Please provide your principle and primary practice location where this registration may be issued. This must be a Missouri practice location where patient care occurs and controlled substance activities take place. It must be a physical street address and not a PO Box or mailing address. This should be the primary location of where the practitioner spends the most time. This principle address is what appears on the drug registration certificate. It must match the federal DEA certificate address. Please provide the business telephone number and fax machine number for this location.
- (13) Please check the box to indicate the practice setting type and any types of obligations you have at this location. Please answer questions for the census for services offered at a reduced rate, acceptance of Medicaid, if new patients are being accepted, and chair-side hours per week you work as well as hours for dental assistants and dental hygienists.
- (14)\* If you have secondary and multiple practice locations, you must attach a listing of these addresses as described in field #12 above. The secondary addresses are required. We ask that you would also voluntarily submit the census questions in field #13 for these secondary locations. These secondary locations would be where you prescribe only. If you stock and administer controlled drugs from other secondary locations, each of those must have their own separate registration.
- (15)\* Please provide a separate mailing address if you would like mail sent to an address other than your practice location.
- (16)\* Please provide information on any guilty pleas entered for any controlled drug violations, regardless of what sentence was finally imposed. This includes guilty pleas and suspended sentences. Please indicate whether this information is already on file with the bureau. If a waiver is required, the employer must obtain a waiver before allowing an employee with guilty pleas or convictions access to their controlled drugs.
- (17)\* Please provide information on any public disciplines, restrictions, probations, surrenders, or revocations taken by administrative regulatory agencies on either your professional license or your state or federal controlled substance registrations. Please indicate if any such regulatory discipline is in process or pending.
- (18)\* Section 195.040.2, RSMo states that no registration may be issued to any person who is abusing controlled substances. Please indicate whether the applicant is abusing or has abused or been treated for or diagnosed with addiction regarding controlled substances during the past year. For purposes of this subsection, "abusing" or "abused" means using or having used a controlled substance in a manner not authorized under Chapter 195, RSMo.
- (19)\* This field provides instructions on what fees must be paid and how to pay the fees. The annual fee is \$30 dollars for a one-year registration. An additional late fee of \$10 is required if the practitioner has expired and lapsed in registration for a period greater than 15 calendar days. No fee is required if the practitioner is employed by a government agency. The applicant claiming exemption must name the government agency. This free registration is restricted to the registrant's government work only. If the registrant wants to practice in the private sector the registrant must pay a fee for a registration.
- (20) This field provides information on how paper applications are to be mailed or delivered to the department.
- (21)\* Applicants are required to physically and manually sign and date an application that is submitted on paper.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
BUREAU OF NARCOTICS AND DANGEROUS DRUGS

**DENTAL APPLICATION FOR A CONTROLLED SUBSTANCES REGISTRATION  
AND PRACTITIONER AVAILABILITY CENSUS**

PLEASE USE THE ATTACHED INSTRUCTIONS THAT APPEAR AT THE END OF THIS FORM.

**\* IS REQUIRED FIELD**

*1.  <input type="checkbox"/> First Time Registration		PREVIOUS BNDD# IF YOU HAVE BEEN PREVIOUSLY REGISTERED		
*2. SOCIAL SECURITY NUMBER (REQUIRED BY 454.403, RSMO)		*DATE OF BIRTH (MM/DD/YYYY)		
<b>*3. TYPE OF BUSINESS ACTIVITY – PRACTITIONER</b>				
PROFESSIONAL LICENSE NUMBER				
or <input type="checkbox"/> License is pending				
<input type="checkbox"/> DDS <input type="checkbox"/> DMD <input type="checkbox"/> DENTAL STUDENT		OTHER STATES YOU ARE LICENSED IN		
*4. LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX	
*GENDER  <input type="checkbox"/> Male <input type="checkbox"/> Female				
*RACE (CHECK ONE)				
<input type="checkbox"/> Caucasian <input type="checkbox"/> African-American <input type="checkbox"/> Asian Indian <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native				
<input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian <input type="checkbox"/> Chamorro <input type="checkbox"/> Japanese				
<input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Samoan				
<input type="checkbox"/> Multiracial/Other				
*ETHNICITY (CHECK ONE)				
<input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican-American <input type="checkbox"/> Chicano <input type="checkbox"/> Non-Hispanic				
<input type="checkbox"/> Other Non-Hispanic/Latino <input type="checkbox"/> Spanish <input type="checkbox"/> Puerto Rican				
5. FLUENT LANGUAGES (MAY CHECK MULTIPLE)				
<input type="checkbox"/> English <input type="checkbox"/> Spanish or Spanish Creole <input type="checkbox"/> German <input type="checkbox"/> French (Incl. Patois & Cajun) <input type="checkbox"/> Chinese				
<input type="checkbox"/> Vietnamese <input type="checkbox"/> Serbo-Croatian <input type="checkbox"/> Italian <input type="checkbox"/> Russian <input type="checkbox"/> Arabic				
<input type="checkbox"/> Korean <input type="checkbox"/> Tagalog <input type="checkbox"/> African Languages <input type="checkbox"/> Other West Germanic				
6. EMAIL ADDRESS			<b>*7. CERTIFICATION</b>  <input type="checkbox"/> Board certified <input type="checkbox"/> Board eligible  <input type="checkbox"/> Not applicable	
<b>*8. PRIMARY SPECIALTY</b>				
<input type="checkbox"/> Endodontist <input type="checkbox"/> General Practice <input type="checkbox"/> Oral Pathologist <input type="checkbox"/> Oral Surgeon				
<input type="checkbox"/> Orthodontist <input type="checkbox"/> Pedodontist <input type="checkbox"/> Periodontist <input type="checkbox"/> Prosthodontist				
<b>*10. CONTROLLED SUBSTANCE SCHEDULES REQUESTED</b>			<b>*9. DEA NUMBER IF YOU HAVE ONE</b>	
<input type="checkbox"/> Schedule II – (opiates, morphine, oxycodone, meperidine) <input type="checkbox"/> Schedule III – (acetaminophen w/codeine)				
<input type="checkbox"/> Schedule IV – (benzodiazepines, alprazolam, diazepam, ativan) <input type="checkbox"/> Schedule V – (diphenoxylate)				

**\*11. ANTICIPATED DRUG ACTIVITY**

Prescribe only — no stock on site       Prescribe, stock, dispense, and administer controlled drugs on site

**\*12. PRIMARY PRACTICE LOCATION** (Must be a physical Missouri address where patient care occurs and controlled drug activity takes place. This must be your principle location where you spend the most time.)

STREET ADDRESS

CITY	STATE	ZIP CODE	COUNTY
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BUSINESS PHONE NUMBER	BUSINESS FAX NUMBER
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**13. PRACTICE SETTING TYPE**

<input type="checkbox"/> Community Health Center	<input type="checkbox"/> Correctional Facility	<input type="checkbox"/> Dental School	<input type="checkbox"/> Free Clinic
<input type="checkbox"/> Hospital	<input type="checkbox"/> Military facility or other federal facility	<input type="checkbox"/> Mobile Dentistry	<input type="checkbox"/> Nursing Home/LTCF
<input type="checkbox"/> Other State Facility	<input type="checkbox"/> Private Office	<input type="checkbox"/> Public Health	

**OBLIGATION TYPES**

<input type="checkbox"/> J-1 VISA	<input type="checkbox"/> National Health Service Corps	<input type="checkbox"/> National Interest Waiver
<input type="checkbox"/> None	<input type="checkbox"/> State Loan Repayment	

**DO YOU PERFORM SERVICES AT A REDUCED RATE, USING A SLIDING FEE SCALE, FOR INDIVIDUALS WITH QUALIFYING INCOMES?**

Yes     No

<b>DO YOU ACCEPT MEDICAID?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>DO YOU ACCEPT NEW PATIENTS?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>*ENTER THE NUMBER OF CHAIR SIDE HOURS PER WEEK YOU WORK AT THIS LOCATION</b>  <p style="text-align: center;">PER WEEK</p>	<b>EXCLUDING DENTAL HYGIENISTS, HOW MANY DENTAL ASSISTANTS DO YOU EMPLOY AT THIS LOCATION?</b>
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**\*ENTER THE TOTAL NUMBER OF CHAIR SIDE HOURS PER WEEK THE ABOVE ASSISTANTS WORK AT THIS LOCATION**  
  

PER WEEK

NAMES OF HYGIENISTS AT THIS LOCATION AND THEIR CHAIR SIDE HOURS PER WEEK AT THIS LOCATION

**\*14. If you have secondary practice locations, please submit the information for Sections 12 & 13 above for each additional location.**

You have now completed Sections 12 & 13 that describes your primary practice location. Your controlled drug registration must be at your principle practice location where you spend the most time. If you have a secondary or additional practice locations, please complete the questions for Section 10 above and provide that additional information with your application for the secondary locations.

<b>*15. MAILING ADDRESS</b> (If you would like your mail sent to a separate address other than practice location)		
STREET ADDRESS		TELEPHONE NUMBER
CITY	STATE	ZIP CODE

**\*16. CRIMINAL HISTORY INFORMATION**

*This question pertains to not only criminal convictions, but also any pleas of guilty, no contest, nolo contendere, or cases where probation was received, even if convictions were later removed. This applies to any guilty pleas for any drug offenses regardless of the final sentence or outcome.*

Has the applicant or any employees of the applicant who have access to controlled substances, ever pled guilty, nolo contendere, no contest, or otherwise ever been convicted of any violation of any state or federal law relating to controlled substances?

Yes    No

If yes, a copy of the conviction information must be on file with the bureau. Has the information been previously submitted?

Yes    No   *If no, please provide the required information with this application.*

If the applicant answered yes to the questions regarding convictions or guilty pleas, a waiver must be obtained before an employee can have access to any controlled substances. A waiver may be applied for at the bureau's website [www.health.mo.gov/BNDD](http://www.health.mo.gov/BNDD) under the link to applications and forms. There is an application for a waiver. Has the employer already obtained a waiver for the employee at this practice location?

Yes    No

**\*17. ADMINISTRATIVE LICENSURE AND REGISTRATION DISCIPLINE HISTORY**

Have any of the applicant's state professional licenses, or state or federal controlled substances registrations, ever been revoked, surrendered, suspended, restricted, or placed on probation — or has any application for a professional license or a state or federal controlled substances registration ever been denied?

Yes    No

If you answered yes, please attach a copy of the discipline.    Already on file with the BNDD

Although a disciplinary action may not be finalized, is such an action pending?

Yes    No

*These questions apply to administrative and regulatory discipline for licenses and registrations. This question is not for criminal convictions.*

**18. UNAUTHORIZED USE/ABUSE OF CONTROLLED SUBSTANCES**

*Unauthorized use and abuse of controlled substances is defined by the bureau as possessing, self-administering or ingesting a controlled substance that was not legally obtained, possessed or authorized by a legitimate medical practitioner acting within the scope of professional practice. All activities with controlled substances must be authorized by Chapter 195, RSMo.*

During the past year, have you abused any amount of a controlled substance not authorized by law?

Yes    No   *(This would be controlled drugs not legally obtained or legally prescribed)*

During the past year, have you been diagnosed with or received any treatment for chemical dependency or addiction relating to controlled substances?

Yes    No

**\*19. PAYMENT OF FEES**

The annual fee is \$30 dollars for a one-year registration. These are processing fees and are not refundable. The fee must accompany the application. Fees may be paid by personal or certified check, cashier's check or money order. Checks should be made payable to the Missouri Department of Health and Senior Services. You are exempt from paying fees if you are employed by a government agency. Having a fee exempted registration restricts your practice to only the government location. If you practice with controlled substances at a non-government location, you must obtain a separate registration and pay the appropriate fee.

Are you employed by a government agency and exempt from fees?

Yes    No

If yes, please provide the name of the government agency: \_\_\_\_\_

If your former registration has expired more than 15 days, an additional \$10 late fee is required.

**\*20. MAILING INFORMATION**

Applications should be mailed to the FEE RECEIPTS UNIT, Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO 65102-0570.

Applications delivered by hand or by special courier should be delivered to the physical street address of the FEE RECEIPTS UNIT, Missouri Department of Health and Senior Services, 920 Wildwood Drive, Jefferson City, MO 65109.

**\*21. SIGNATURE & ACKNOWLEDGEMENT**

Submitting an incomplete application delays processing. Submitting false information on an applications grounds for a denial of registration or other administrative disciplinary action pursuant to Section 195.040, RSMo. The duty and responsibility for applying for a registration cannot be delegated.

PRINTED NAME OF APPLICANT	TITLE
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SIGNATURE OF APPLICANT	DATE
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