Missouri Department of Health and Senior Services
P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010
RELAY MISSOURI for Hearing and Speech Impaired 1-800-735-2966 VOICE: 1-800-735-2466

Dear Applicant:

Attached is an application for a Missouri Controlled Substances Registration and instructions for completing the application. 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 practitioner 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. Long-term care facilities 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 by the Department's Fee Receipt Unit before being forwarded to the Bureau of Narcotics and Dangerous Drugs for processing and issuing of registrations.

(6) The Bureau no longer mails controlled substance registration certificates. Registration certificates can be verified or printed at the Bureau's website **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 ensure handwriting is legible.

(8) All applications submitted on paper must be mailed or delivered to the Department's Fee Receipt Unit at the following addresses:

Mailing address:
Department of Health and Senior Services
Fee Receipt Unit
P.O. Box 570
Jefferson City, MO 65102-0570

Hand delivery address:
Department of Health and Senior Services
Fee Receipt Unit
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**

INSTRUCTIONS FOR COMPLETING MID-LEVEL PRACTITIONER APPLICATION

Please review these instructions as the application is completed to ensure 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. Please be sure to write legibly.

*(1) Provide your full legal name. This will be printed on your registration. The name on this registration and the federal DEA registration must match.

*(2) Indicate if this is your first Missouri Controlled Substances Registration ever or provide your previous/existing registration number if you have had a previous registration.

*(3) A social security number is required pursuant to Section 454.403, RSMo. Applicants are also required to submit their date of birth (MM/DD/YYYY).

*(4) Indicate if you hold a current professional license, the type of license and the license number. It is possible that some researchers may not have a professional license. Name the agency or state board that issued the license. If your are licensed to practice in other states, indicate the names of the states.

(5) Identify your primary specialty group, primary specialty and certification status. Identify secondary and tertiary specialties also.

*(6) Indicate your gender, race and ethnicity. As part of the voluntary census, we ask that you indicate what language(s) you speak fluently.

(7) Provide your current email address where the Bureau of Narcotics and Dangerous Drugs may contact you or send information.

*(8) Provide your current DEA number, if you have one. If you do not have one, leave this blank or write in the word “pending.”

*(9) Indicate the controlled substance schedules for which you are requesting authority. A complete listing of drugs by name and schedule appear on the BNDD’s website **www.health.mo.gov/BNDD** under the link to publications.

*(10) If you have any collaborative or supervision agreements pursuant to Chapter 334, RSMo, provide a list of the names, license numbers and expiration dates of each of the mid-level practitioners with which you have an agreement.

*(11) 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 location 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. Provide the business telephone number and fax machine number for this location.

*(12) Provide a breakdown of the work hours you practice each week. If you have secondary practice locations, please provide the address of the secondary locations and the number of hours at those secondary locations. Additional sheets may be attached if necessary.

(13) Indicate the practice setting for the primary location and any type of obligations at that location. For census purposes, the department would like to know if you offer services at a reduced rate, if you accept Medicaid and if you accept new patients.

(14) You may provide a separate mailing address if you want your mail sent to a different location than your practice address. This mailing address may be a PO Box. This mailing address must be in the United States.

*(15) 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 to have any access to controlled drugs.

*(16) 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. Indicate if any such regulatory discipline is in process or pending.

*(17) Section 195.040.2, RSMo states that no registration may be issued to any person who is abusing controlled substances. 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.

(18) This field provides instructions on the amount fees that must be paid and how to pay the fees. Fees are $30 for an annual 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.

(19) This field provides information on how paper applications are to be mailed or delivered to the department.

*(20) Applicants are required to manually sign and date an application that is submitted on paper.

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

MID-LEVEL PRACTITIONER APPLICATION FOR A MISSOURI CONTROLLED SUBSTANCES REGISTRATION AND PRACTITIONER AVAILABILITY CENSUS

PLEASE USE THE ATTACHED INSTRUCTIONS THAT APPEAR WITH THIS FORM. (*) REQUIRES A RESPONSE.

*1. YOUR LEGAL NAME LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

*2. ☐ First Time Registration	PREVIOUS BNDD# IF YOU HAVE BEEN PREVIOUSLY REGISTERED

*3. SOCIAL SECURITY NUMBER (REQUIRED BY SECTION 454.403, RSMO)	*DATE OF BIRTH (MM/DD/YY)

TYPE OF BUSINESS ACTIVITY - MID-LEVEL PRACTITIONER

*4. PROFESSIONAL LICENSE NUMBER

☐ Advanced Practice Nurse ☐ Physician's Assistant ☐ Assistant Physician

NAME OF STATE LICENSING AGENCY OR BOARD

OTHER STATES YOU ARE LICENSED IN

5. APRNs PRIMARY SPECIALTY GROUP

☐ Acute Care	☐ Administration	☐ Adult Health
☐ Adult Psych / Mental Health	☐ Cardiac Nursing	☐ Case Management
☐ Child / AdolescentPsych / Mental Health	☐ Community Health	☐ Consultant
☐ Diabetes Management	☐ Education	☐ Family Health
☐ General Nursing	☐ Gerontological Nursing	☐ Home Health
☐ Infection Control	☐ Informatics	☐ Medical-Surgical
☐ Neonatal	☐ Occupational / Industrial Health	☐ Oncology
☐ Other _____	☐ Pain Management	☐ Patient Care
☐ Pediatric	☐ Public Health	☐ Quality Assurance
☐ Research	☐ School Nursing	☐ Utilization Review
☐ Women's Health		

PRIMARY CERTIFICATION

☐ Board Eligible ☐ Board Certified ☐ Not Applicable

SECONDARY SPECIALTY	SECONDARY CERTIFICATION STATUS
TERTIARY SPECIALTY	TERTIARY CERTIFICATION STATUS

*6. GENDER

☐ Male ☐ Female

*RACE (CHECK ONE)

☐ Caucasian ☐ African-American ☐ Asian Indian ☐ American Indian ☐ Alaskan Native

☐ Chinese ☐ Filipino ☐ Guamanian ☐ Chamorro ☐ Japanese

☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan

☐ Multiracial/Other

*ETHNICITY (CHECK ONE)

☐ Cuban ☐ Mexican ☐ Mexican-American ☐ Chicano ☐ Non-Hispanic

☐ Other Hispanic/Latino ☐ Spanish ☐ Puerto Rican

FLUENT LANGUAGES (MAY CHECK MULTIPLE)

☐ English ☐ Spanish or Spanish Creole ☐ German ☐ French (Incl. Patois & Cajun) ☐ Chinese

☐ Vietnamese ☐ Serbo-Croatian ☐ Italian ☐ Russian ☐ Arabic

☐ Korean ☐ Tagalog ☐ African Languages ☐ Other West Germanic

7. EMAIL ADDRESS	*8. DEA NUMBER (IF APPLICABLE)

***9. CONTROLLED SUBSTANCE SCHEDULES REQUESTED**

☐ Schedule II ☐ Schedule III — (testosterone, acetaminophen/codeine)

☐ Schedule IV — (benzodiazepines, alprazolam, diazepam) ☐ Schedule V — (diphenoxylate, pregablin)

*10. Please list the name(s) of physician(s) you have agreements with:

NAME(S)	MD OR DO	LICENSE #	EXPIRATION DATE

***11. 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
BUSINESS PHONE NUMBER	BUSINESS FAX NUMBER		

*12. PLEASE PROVIDE THE NUMBER OF HOURS YOU WORK/PRACTICE EACH WEEK IN THE SPACES BELOW

_____ Direct patient care (non-hospital) _____ Inpatient hospital care _____ Administration

_____ Research _____ Teaching _____ Other

***If you have secondary practice locations, please submit the information for Sections 11 & 12 above for each additional location. You may staple these additional sheets and location information to this application.**

13. PRACTICE SETTING TYPE

☐ Community Health Center ☐ Correctional Facility ☐ Free Clinic ☐ Group Health Plan (HMO)

☐ Hospital ☐ Military facility or other federal facility ☐ University Hospital ☐ Nursing Home/LTCF

☐ Other State Facility ☐ Private Office ☐ Public Health ☐ School of Medicine

OBLIGATION TYPES

☐ J-1 VISA ☐ National Health Service Corps ☐ National Interest Waiver

☐ None ☐ State Loan Repayment

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

☐ Yes ☐ No

DO YOU ACCEPT MEDICAID?	DO YOU ACCEPT NEW PATIENTS?
☐ Yes ☐ No	☐ Yes ☐ No

14. MAILING ADDRESS *(If you want your mail sent to a separate USA mailing address other than primary practice location)*

STREET ADDRESS		TELEPHONE NUMBER
CITY	STATE	ZIP CODE

***15. 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** 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

***16. ADMINISTRATIVE LICENSURE AND REGISTRATION DISCIPLINE HISTORY**

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

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

***17. 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

18. PAYMENT OF FEES

The annual fee is $30 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 employment 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.

19. MAILING INFORMATION

Applications should be mailed to the Missouri Department of Health and Senior Services, FEE RECEIPT UNIT, 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 RECEIPT UNIT, at the Missouri Department of Health and Senior Services, 920 Wildwood Drive, Jefferson City, MO 65109.

***20. 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

SIGNATURE OF APPLICANT	DATE

Please review the application to ensure you have responded to the required fields with an asterisk(*). Please attach any documents that are required. Additional information, statutes, regulations, and educational handouts are available on the Bureau's website at www.health.mo.gov/BNDD.