State of West Virginia
Board of Medicine

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Controlled Substance Dispensing Practitioner Registration Form for Physicians, Podiatric Physicians and Physician Assistants

To dispense or administer a controlled substance in an office-based setting, licensees of the Board must be registered as a controlled substance dispensing practitioner at each office location where the practitioner dispenses or administers controlled substances. Registration forms from physician assistants must be accompanied by a copy of a current authorized practice agreement, which includes a delegation of dispensing authority consistent with the submitted application. To register, please provide the following information.

1. **Practitioner Information.**

First Name Middle Name Last Name Suffix Profession(MD/DPM/PA)

WVBOM License Number DEA Controlled Substance Registration Number

2. **Controlled Substance Dispensing Locations.** Please list each and every location for which you seek registration for the office-based dispensing of controlled substance medication. If you have additional locations, please attach a separate sheet of paper to your application which identifies all additional locations in a numbered list which conforms with the format below:

Dispensing Location No. 1

Physical Address City State Zip Code County Telephone

Dispensing Location No. 2

Physical Address City State Zip Code County Telephone

Dispensing Location No. 3

Physical Address City State Zip Code County Telephone

Dispensing Location No. 4

Physical Address City State Zip Code County Telephone

3. **Verification of CSMP Status.** Please select the statement which applies to you:

______ I am currently registered to access the West Virginia Controlled Substance Monitoring Program (WVCSMP) Database.

______ I do not prescribe, administer or dispense any Schedule II, III or IV Controlled Substances pursuant to my West Virginia license, and I am therefore not registered to access the West Virginia Controlled Substance Monitoring Program (WVCSMP) Database.

4. **Eligibility to Register as a Controlled Substance Dispensing Practitioner.** Please verify that each of the following statements are true and correct by initialing the line in front of each statement. If you are unable to verify any of the statements below, you are ineligible to register.

______ My DEA controlled substance registration number, which I have provided, is valid, unexpired and is not subject to any restrictions or limitations.

______ I have never pled guilty (or no contest) to, and have never been adjudged guilty of, a felony relating to controlled substances in any jurisdiction.

______ I am not subject to any administrative or court order in any jurisdiction which places restrictions or limitations of any kind upon my prescriptive authority and/or ability to prescribe.

______ I understand and agree to comply with my obligation to report the dispensing of controlled substances to the WVCSMP.

5. **Registration Fee.** Your initial period of registration will expire with your practitioner license. To determine the appropriate fee for your initial registration, please use the applicable table below.

MDs (A-L)

How many physical locations are you seeking to register as drug dispensing locations?	
Multiply your total number of locations by $15.00 to determine your registration fee.	**x $15.00**
I have enclosed a drug dispensing renewal registration fee payment in the amount of:	

MDs (M-Z), DPMs and PAs

How many physical locations are you seeking to register as drug dispensing locations?	
Multiply your total number of locations by $30.00 to determine your registration fee.	**x $30.00**
I have enclosed a drug dispensing renewal registration fee payment in the amount of:	

6. **Attestation.**

By placing my original, dated signature upon this application, I attest that the information I have provided is truthful, accurate and complete.

_________________________________ _________________________

Practitioner's Signature Date

7. **Authorization for Physician Assistant Applicants.**

As the collaborating physician for this controlled substance dispensing practitioner applicant, I authorize the submission of this registration form.

______________________________________ ___________________________ __________

Printed Name of Collaborating Physician Signature Date