



**MARYLAND DEPARTMENT OF HEALTH - PUBLIC HEALTH SERVICES
OFFICE OF CONTROLLED SUBSTANCES ADMINISTRATION (OCSA)**

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(Revised: 9/8/2022)

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|----------------------------------|--|---------------|
| ESTABLISHMENT APPLICATION | CDS APPLICATION FOR 3-YEAR REGISTRATION | CDS #: |
|----------------------------------|--|---------------|

I. Federal Establishments

Effective April 21, 2014, the Office of Controlled Substances Administration ("OCSA") discontinued issuing CDS Registrations to Federal establishments and to practitioners and researchers that practice within a Federal facility or on Federal property. Please do not mail in the CDS application with a Federal business address. The CDS application will be returned without a refund of the application fee.

FOR OFFICE USE ONLY: APPLICATION AUDIT CONTROL SECTION

Processor Initials: _____

Date: ____/____/____

Note:

Do Not Write In This Section.

SEE INSTRUCTIONS ATTACHED. COMPLETE ALL SECTIONS 1, 2 AND 3 BELOW. SIGN, DATE APPLICATION AND INCLUDE PAYMENT. APPLICATIONS TORN IN HALF, INCOMPLETE OR WITHOUT PAYMENTS WILL BE RETURNED, WHICH DELAYS PROCESSING. **REQUIRED:** UPDATED ESTABLISHMENT QUESTIONNAIRE (EQ) OR COPY OF APPROPRIATE LICENSE (L) AND EMAIL ADDRESS FOR RENEWAL NOTIFICATION. * **KEEP A COPY OF APPLICATION.**

SECTION 1: APPLICATION CLASSIFICATION, TYPE, PAYMENT AND FEE EXEMPT DETAILS

A. CLASSIFICATION - Check only one box . For lawful registration, separate application required for each Establishment Classification.

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|--|---|
| Automatic Dispensing Systems (II-V) (L) Animal Control Facility (II-III) (L) Assisted Living Facility (II-V) (L) Clinics (II-V) (L)(EQ) Drug/Alcohol Programs (II-V) (L) Hospital (Human/Animal) (II-V) (L) Long Term Care (II-V) (L) Methadone (II-V) (L) Pharmacy (II-V) (L) | <p align="center">Check which Schedules Apply: I II III IV V</p> Distributor (L)(EQ) Exporter (L)(EQ) Importer (L)(EQ) Manufacturer (L)(EQ) Laboratory-Analytical (EQ) Law Enforcement Agency-K-9 (EQ) |
| Non Resident Pharmacy (II-V) (EQ) | |

| B. FEE PAYMENT DETAILS | FOR OFFICE USE ONLY | C. FEE EXEMPT DETAILS FOR GOVERNMENT AGENCIES | |
|---|--------------------------------------|---|--|
| <i>(Fee Payable to MDH-OCSA)</i> | App. Receive Date: / / | CHECK TYPE: State Local (Agency Unit Code): | |
| TYPE | Deposit Date: / / | Agency/Institution Name | |
| Renewal** | Check/Mo #: _____ | Division/Department | |
| New | Check/Date: _____ | Agency/Institution Business Address | |
| Address Change Only | Processor Initials: _____ | Contact Telephone # | |
| Name Change Only | Do Not Write In This Section. | Print Certifier Name | |
| Duplicate CDS Permit | | Date: / / | |
| Change of Ownership | | (Signature of Certifier) | |
| Closing | | | |
| <i>(Fees are Non-Refundable.)</i> | | | |
| **No additional fee for Name or Address change at time of renewal. | | | |

| SECTION 2: APPLICANT DETAILS | SECTION 3: PROFESSIONAL LICENSE DETAILS |
|---|--|
| A. Establishment Name/DBA B. Responsible Person Name (print) (First) (Middle) (Last) C. Title D. Business Address City/State/Zip County E. Mailing Address City/State/Zip <i>(If different than D)</i> F. Telephone Nos. Business No.: _____ Fax No. (Required): _____ Alternate or Cell No.: _____ G. Email* (Required) | A. Health Occupational Board, OHCQ, Other License #: _____ Expiration Date: ____/____/____ B. Federal DEA #: _____ Expiration Date: ____/____/____ C. Tax ID Number: _____ D. Has your federal, State or Health Occupational license ever been denied, suspended, restricted, revoked, reprimanded, or placed on probation? Yes No E. Has the responsible person ever been convicted of a violation of law pertaining to CDS? Yes No F. Have restrictions been placed on the entity's handling of CDS? Yes No <div style="background-color: #92d050; padding: 5px; text-align: center;"> If yes is the answer to any of the above questions, submit a detailed explanation and copies of pertinent/supporting documentation. </div> <p>***Please provide the effective date for a change of ownership, relocation of facility, and/or name change: Please contact OCSA if the effective dates changes from the original date provided.***</p> <p>SIGNATURE OF RESPONSIBLE PERSON: _____ DATE: ____/____/____</p> |

Your signature attests to the fact that the information provided is accurate. It is the sole and continuing responsibility of the CDS Registrant to ensure the Office of Controlled Substances Administration (OCSA) has the correct and current address information on file for the issued CDS Registration.