MARYLAND DEPARTMENT OF HEALTH - PUBLIC HEALTH SERVICES
OFFICE OF CONTROLLED SUBSTANCES ADMINISTRATION (OCSA)
1223 West Pratt Street, Baltimore, Maryland 21223
OCSA Website: https://health.maryland.gov/ocsa ◘ OCSA Email: Maryland.OCSA@Maryland.Gov
Main Office: (410) 764-2890 ◘ Fax: (410) 358-1793 ◘

(Revised: 6/4/26)

PRACTITIONER APPLICATION	3 Year CDS REGISTRATION APPLICATION	CDS #:

I. PDMP Mandate Effective February 15, 2018

All MD Practitioners must register with the **Prescription Drug Monitoring Program (PDMP) prior to obtaining a new or renewal CDS Registration. To register with PDMP, go to the CRISP website at** https://crisphealth.org/. Submit to OCSA the PDMP email confirmation that includes the confirmation code number. If you believe you are already registered but no longer have access to your confirmation code please contact CRISP on their website above or by phone (877) 952-7477. Do not mail the CDS application until you are registered with PDMP.

FOR OFFICE USE ONLY: APPLICATION AUDIT CONTROL SECTION	Processor Initials: _______ Date:____/_____/____ Note:

Do Not Write In This Section.

II. Federal Establishments, Practitioners and Researchers

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

III. 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 DELEGATION AGREEMENT, RESEARCHER QUESTIONNAIRE, DOCUMENTATION LISTED IN INSTRUCTIONS, 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 ☑: ☐ BDS ☐MD ☐DDS ☐DMD ☐DO ☐DPM ☐DVM ☐VMD ☐CRNP ☐CNM ☐EMS/Med.Dir.
☐**Pharmacist Schedules II, III, IV, V**
☐ **PA/New: Attach Delegation Approval Email or Letter** (With CDS Prescriptive Authority Summary and supervisory physician name required) (**Required**)
☐ **PA/Renewal: Insert Supervising Physician name ______________________(Required)**
☐ **Researcher Schedule I (Prior DEA approval)** ☐**Researcher Schedules II, III, IV, V (All Researchers must submit a Researcher Questionnaire.)**
See instructions for other documentations required. Lawful registration requires separate application for each Profession.

B. FEE PAYMENT DETAILS		FOR OFFICE USE ONLY
(Fee Payable to MDH-OCSA)		App. Receive Date: / /
TYPE	***FEE***	Deposit Date: / /
Renewal**	☐ $120	Check/Mo #:
New	☐ $120	Check Date:
Address Change Only	☐ $50	Processor Initials:
Name Change Only	☐ $50	Do not write in this section.
Duplicate CDS Permit	☐ $30	
Discontinuation (List Reason):	☐ $0	
(Fees are Non-Refundable.)		

No fee for name/address change at time of renewal.

C. FEE EXEMPT DETAILS FOR GOVERNMENT AGENCIES	
CHECK TYPE: ☐ State ☐ Local (Agency Unit Code):	
Agency/Institution Name	
Division/Department	
Agency/Institution Business Address	
Contact Telephone #	
Print Certifier Name	
Title of Certifier	
Date: / /	(Signature of Certifier)

SECTION 2: APPLICANT DETAILS

A. Name (print)	(First)
	(M.I.)
	(Last)
B. Physical Business Name:	
C. Maryland Physical Business Address (Triggers Inspection if Not Provided) **No.** **Street:**	
City/State/Zip Code:	
D. Mailing Address	
City/State/Zip	
E. Home Address	
City/State/Zip	
F. Telephone Nos.	Business No.:
	Fax No.:
	Alternate or Cell No.:
G. Email* (**Required**)	
H. Please provide the PDMP registration Date: ____/_____/________ **PDMP Registration Confirmation Code No:** ______________________________	

SECTION 3: PROFESSIONAL LICENSE DETAILS

A. Professional License #:	Expiration Date: / /
B. Federal DEA #:	Expiration Date: / /
C. Social Security or Tax ID#:	
D. Is your professional license currently or has it ever been denied, suspended, restricted, revoked reprimanded or placed on probation?	☐ **Yes** ☐ **No**
E. Is your license currently under any restriction or on probation for reasons related to CDS by a Health Occupations Board, a State or federal agency?	☐ **Yes** ☐ **No**
F. Has there been adverse action taken against your Professional license in another state/country?	☐ **Yes** ☐ **No**
G. Have you ever been convicted of a felony violation or a violation pertaining to your profession?	☐ **Yes** ☐ **No**

If yes is the answer to any of the above questions, submit a detailed explanation and copies of pertinent/supporting documentation.

SIGNATURE:	**DATE**: / /

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 has the correct and current address information on file for the issued CDS Registration.