Form-224

APPLICATION FOR REGISTRATION

APPROVED OMB NO 1117-0014 FORM DEA-224 (04-12)

	Und	er the Controlle	ed Substar	nces Act	t				FOF	RM EXPIR	ES: 01/3	31/2016
INSTRUCTIONS	Save time - appl	y on-line at ww	w.deadive	rsion.us	doj.gov	v	DEA C	FFICIA	L USE	:		
	 To apply by mail comp Mail this form to the a 	olete this application. K ddress provided in Sec	eep a copy for tion 7 or use en	your records closed enve	s. elope.				П			
	The "MAIL-TO ADDRES If you have any quest	s" can be different than ions call 800-882-9539	your "PLACE OF prior to submitt	F BUSINESS' ing your app	address. dication.		Do you	u have o	ther Di	EA registr	ation nur	mbers?
	IMPORTANT: DO NOT	SEND THIS APPLICAT	ION and appl	Y ON-LINE				10		Y	'ES	
MAIL-TO ADDRESS	Please print mailing a	ddress changes to the	ne right of the	address in	n this box) YEARS		1
							FEE IS	5 NON-I	REFUI	NDABLE		
OF OTION 4									_			
	PPLICANT IDENTIFICAT ast Name of individual -OF		v Name)	Individua	al Registr	ration		Busin	ess Re	gistratio	1	
			, ,					TI	J	T		
Name 2 (Fi	rst Name and Middle Nam	e of individual - OR-	Continuation	of busines	ss name)				7			
					TÍ	N		K	ŤТ			
PLACE OF BUS	INESS Street Address Lin	e 1										
			TK									
PLACE OF BUS	INESS Address Line 2											
				NI								
City						5	State	Zip Cod	de			
Business Phone	Number	Point of Contact										
Business Fax N	umber	Email Address										
DEBT COLLECTION INFORMATION	Social Security Number (f registration is for in	dividual)			Tax Id	entifica	 tion Num	– – – – ıber (<i>if ı</i>	egistration	is for bu	 usiness)
Mandatory pursuant to Debt Collection			Provide SS See additio		ion	П	7.0		П			
Improvements Act			note #3 on		. – – – –							
FOR	Professional Degree: select from	Professional School :								∕ear of Graduation	:	
Practitioner or	list only					D-4-	- f D:-41-	(444.55	2 2000	Λ.		
MLP ONLY:	National Provider Identific	cation:						(MM-DE)- Y Y Y Y): .7 x7		
						MA		D	Y	YY		
SECTION 2 BUSINESS ACTIVITY	Central Fill Pharmac	y	Prac	ctitioner S, DMD, DC	, DPM, DV	/M, or N	ID)			Ambula	nce Ser	vice
Check one business activity	Retail Pharmacy		L (DDS	ctitioner M S, DMD, DC), DPM, DV		ID)			Animal	Shelter	
box only	Nursing Home		Mid-	-level Prac M, HMD, MF	titioner (N P, ND, NP, (MLP) OD, PA,	or RPH)		Hospita	al/Clinic	
	Automated Dispensi	ng System (ADS)	Euth	nanasia Te	chnician				[Teachir	ng Institu	tion
FOR Automated Dispen (ADS) ONLY:		legistration # ail Pharmacy ADS						Skip S	ection 6	omatically for and Section tha notorize	n 7 on pag	ge 2.
SECTION 3 DRUG SCHEDULES	Schedule 2 Na	cotic	Sc	hedule 3 N	larcotic					Schedule 4		

Schedule 3 Non-Narcotic (3N)

Schedule 2 Non-Narcotic (2N)

Check this box if you require official order forms - for purchase of schedule 2 controlled substances.

Check all that apply

Schedule 5

SECTION 4 STATE LICENSE(S)	You MUST be currently autho in the schedules for which you	rized to prescribe, di u are applying under	stribute, dispen the laws of the	ise, conduct state or juris	researc sdiction	ch, or oth in which	nerwise h you a	e handle are oper	the coating o	ntrolle r prop	ed sub ose to	stance: operat	s te.
MANDATORY	State License Number							Expirat Date	ion	1	1		
Be sure to include both state license numbers		What state was this	license issued	in?					N	1M - E)D - `	YYYY	
	State Controlled Substance License Number							Expirat Date		/ 1M - E	/	VVVV	
		What state was this	license issued	in?					IV	'IIVI - L	- טל	1111	
SECTION 5											YE	S NO	
LIABILITY oa	as the applicant ever been con r been excluded or directed to b ction pending?	e excluded from part	connection with ticipation in a m	n controlled s ledicare or st	substand ate hea	ce(s) un alth care	der sta progra	ate or feam,or is	deral la any su	aw, ich			
IMPODTANT	ate(s) of incident MM-DD-YYYY as the applicant ever surrender		l a fodoral cont	rolled substa	nco roo	nietration	rovok	od eue	nondo	4	YE	S NO	
All questions in this section must	estricted, or denied, or is any su	ch action pending?	a lederal cont	TOlled Substa	ince reg	gistiatioi	116006	icu, sus	pende	J,	L		
be answered.	ate(s) of incident MM-DD-YYYY										YE	S NO	
3. F ri	as the applicant ever surrender evoked, suspended, denied, res	ed (for cause) or had tricted, or placed on	probation, or is	sional licens any such ac	e or con tion per	ntrolled s	substa	nce regi	stration	1		ш	
	ate(s) of incident MM-DD-YYYY		-								YE	S NO	
10	the applicant is a corporation of artnership, or pharmacy, has an ontrolled substance(s) under stagistration revoked, suspended, egistration revoked, suspended,	restricted, denied, o	r ever nad a st a	ate professio	naı iicer	nse or c	Ontroll	ea subsi	ociation nection substar tance	n, with nce			
С	ate(s) of incident MM-DD-YYYY			Note: If que It will slow	uestion down p	4 does processi	not app	oly to yo our app	u, be s lication	sure to	mark I leave	'NO'. e it blan	k.
EXPLANATION OF "YES" ANSWERS	Liability question #	Location(s) of	f incident										_
Applicants who have answered "YES" to	Nature of incident:	Loodiion(o) o	inolacine								_		
any of the four question above must provide a statement to explain each "YES" answer.													
Use this space or attach a separate sheet and return with application	Disposition of incident:												
a separate sheet and return with application	Disposition of incident:	FEE											
a separate sheet and return with application SECTION 6 EXE			overnment offic	cial or institut	ion. Doe	es not a	pply to	o contrac	ctor-op	erated	institu	utions.	
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WARNING: 21 USC 843(d), states that any person who knowingly or intentionally furnishes false or fraudulent information in the application is subject to a term of imprisonment of not more than 4 years, and a fine under Title 18 of not more than \$250,000, or both.

NEW - Page 2

SECTION 4 STATE LICENSE		You MUST be currently authorized to in the schedules for which you are app	orescr olying	ibe, d under	istribut the lav	e, dis ws of	per the	se, c state	ond or	uct juris	rese sdict	arc ion	h, or in w	otl hic	nerw h yo	ise u a	e har are o	dle th perati	e con	ntrol pro	led su pose	ubsta to op	nces perate.
MANDATORY		State License Number														I							
		What state was this license issued in?																					
Expiration	Date	/ / MM - DD - YYYY	_																				
SECTION 5		WIW - DD - TTTT																				YES	NO
LIABILITY	or	as the applicant ever been convicted o been excluded or directed to be exclud tion pending?	a cri ed fro	me in m par	conne	ction on in	witl a m	n con edica	trolle are c	ed s or st	ubst ate l	an	ce(s) Ith c) ur are	der pro	sta gra	ate o	fede is an	ral la y suc	w, ch			
IMPORTANT	Da	ate(s) of incident MM-DD-YYYY:	H	Ш.		_															,	YES	NO
IMPORTANT All questions in this section must	re	as the applicant ever surrendered (for castricted, or denied, or is any such action	use) pend	or had ing?	a fed	eral o	ont	rolled	sub	osta	nce	reg	istra	itio	rev	/ok	ed, s	uspe	nded	,			
be answered.		ate(s) of incident MM-DD-YYYY:	J-L				6	<u>.</u>	1.12				411	1	!	4			- 4		`	YES	NO
		as the applicant ever surrendered (for ca voked, suspended, denied, restricted, o ate(s) of incident MM-DD-YYYY:	place	or nac ed on	probat	e pro	r is	siona any s	such	ense n act	e or o	con	ding	ea : ?	subs	star	ice r	egistr	ation				Ш
		the applicant is a corporation (other that rtnership, or pharmacy, has any officer, ntrolled substance(s) under state or fed gistration revoked, suspended, restricte gistration revoked, suspended, denied,	n a co partne eral la d, den estric	orpora er, sto iw, or ied, o ited or	ation w ckhold ever su r ever placed	nose er, or urrend nad a d on p	stoo pro dere sta	ck is of prieto ed, for other prieto ed, for other prieto ed, for other prieto ed, for other ed, for	own or be r car ofes , or	ed a een use ssion is a	and t c on , or h nal li ny s	rad vic nad cer uch	ed b ted o a fe ise o acti	oy the de or co	ne p a cri i ral c ontro pen	ubl me con olle din	lic), a in c trolle ed su ig?	issoci onnec d sub bstan	ation tion stan ce	ı, with ce		YES	NO
	Da	ate(s) of incident MM-DD-YYYY:	HL					No:	te: ill s	lf qu low	iestic dow	nc a n	4 do roce	es Issi	not a	app of v	oly to	you, pplica	be su	ure to	o mai	rk 'No ve it	O'. bl <u>ank</u> .
EXPLANATION O "YES" ANSWERS		Liability question # L	 ocatio	n(s) o	f incide	nt: _	_								3 2	- 2		PE25				<u>.</u>	<u> </u>
Applicants who ha answered "YES" to any of the four que above must provi a statement to ex	o estions i de	Nature of incident:																					
each "YES" answ Use this space or a separate sheet a return with applica	ier. attach and	Disposition of incident:																					
SECTION 6	EXEN Check	IPTION FROM APPLICATION FEE this box if the applicant is a federal, state or Facility Name of Fee Exempt Institution		Ĭ											,				•		ed inst	titutio	ons.
Ш						Ш				L	\perp	L	\perp	L	\perp			Ш			Ш		
FEE EXEMPT		The undersigned hereby certifies that and is exempt from payment of the ap	the ap	oplicar on fee	nt name	ed he	reo	n is a	fed	eral	, sta	te (or loc	cal	gove	ern	men	t offici	al or	insti	itutior	٦,	
CERTIFIER		Signature of certifying official (other than		liaant\									_	_	ate				—	—			
Provide the name phone number of t		Signature of Certifying Official (other tha	ш арр	iicaiii)										_	ale								
certifying official		Print or type name and title of certifying	g offic	ial										Te	leph	nor	e No	. (req	uired	for ve	erificat	tion)	
SECTION 7 METHOD OF PAYMENT		Make check payable to: D See page 4 of instructions	rug En for imp	forcen ortant	nent Ac informa	l minis tion.	trat	ion									Ма	il this	form	ı witl	h payı	ment	to:
Check one form of	f	American Express Discover		Maste	er Card		V	isa									DE	A Hea	dqua	arter			
payment only	ı	Credit Card Number							Ex	xpira	ation	Da _	ate				P.O	. Вох	2639	9	on Se 2152-2		/ODR
Sign if paying by credit card		Signature of Card Holder					_										FE	E IS	NON	-RE	FUND	DABI	Æ
STOUR GAIN		Printed Name of Card Holder					_																
OFOTION							,.														—		
SECTION 8 APPLICANT'S SIGNATURE		I certify that the foregoing information	turnisl	ned or	n this a	pplic	atio	n is tr	ue a	and	corr	ect			_								
Sign in ink		Signature of applicant (sign in ink)													Da	ate							
		Print or type name and title of applican	nt										_										

WARNING: 21 USC 843(d), states that any person who knowingly or intentionally furnishes false or fraudulent information in the application is subject to a term of imprisonment of not more than 4 years, and a fine under Title 18 of not more than \$250,000, or both.

STATE LICENSE(S)	, , , , , , , , , , , , , , , , , , , ,	are operating or propose to operate.
MANDATORY		Expiration / /
WWW.Drittori	TEM/Salud Numero	MM - DD - YYYY
	ASSMCA Numero	Expiration / / / Date
		MM - DD - YYYY Expiration , ,
	Colegio de Medicos Numero	Date / / MM - DD - YYYY
SECTION 5		YES NO
LIABILITY O	as the applicant ever been convicted of a crime in connection with controlled substance(s) under a been excluded or directed to be excluded from participation in a medicare or state health care procession pending?	
	ate(s) of incident MM-DD-YYYY:	YES NO
this section must	as the applicant ever surrendered (for cause) or had a federal controlled substance registration revestricted, or denied, or is any such action pending?	okea, suspendea,
	ate(s) of incident MM-DD-YYYY:	YES NO
3. H	as the applicant ever surrendered (for cause) or had a state professional license or controlled subsevoked, suspended, denied, restricted, or placed on probation, or is any such action pending?	tance registration
	ate(s) of incident MM-DD-YYYY:	YES NO
4. IT p C re re	the applicant is a corporation (other than a corporation whose stock is owned and traded by the partnership, or pharmacy, has any officer, partner, stockholder, or proprietor been c onvicted of a cri ontrolled substance(s) under state or federal law, or ever surrendered, for cause, or had a federal cogistration revoked, suspended, restricted, denied, or ever had a state professional license or controligistration revoked, suspended, denied, restricted or placed on probation, or is any such action pendigustration revoked.	JOIC), association, me in connection with controlled substance blied substance ding?
	ate(s) of incident MM-DD-YYYY: Note: If question 4 does not a	pply to you, be sure to mark 'NO'. f your application if you leave it blank.
EXPLANATION OF "YES" ANSWERS	Liability question # Location(s) of incident:	your application if you leave it blaim.
Applicants who have answered "YES" to any of the four question: above must provide a statement to explain each "YES" answer.	Nature of incident:	
Use this space or attach a separate sheet and return with application	Disposition of incident:	
SECTION 6 EXE	MPTION FROM APPLICATION FEE	
Chock	WE HOW I KOM AFF LIGATION TEL	
	this box if the applicant is a federal, state, or local government official or institution. Does not apply	·
		·
	this box if the applicant is a federal, state, or local government official or institution. Does not apply or Facility Name of Fee Exempt Institution. Be sure to enter the address of this exempt institution	on in Section 1.
Business	this box if the applicant is a federal, state, or local government official or institution. Does not apply	on in Section 1.
	this box if the applicant is a federal, state, or local government official or institution. Does not apply or Facility Name of Fee Exempt Institution. Be sure to enter the address of this exempt institution. The undersigned hereby certifies that the applicant named hereon is a federal, state or local government of the application fee.	on in Section 1.
Business FEE EXEMPT	this box if the applicant is a federal, state, or local government official or institution. Does not apply or Facility Name of Fee Exempt Institution. Be sure to enter the address of this exempt institution	on in Section 1.
Business FEE EXEMPT CERTIFIER	this box if the applicant is a federal, state, or local government official or institution. Does not apply or Facility Name of Fee Exempt Institution. Be sure to enter the address of this exempt institution. The undersigned hereby certifies that the applicant named hereon is a federal, state or local government of the application fee. Signature of certifying official (other than applicant) Date	on in Section 1.
FEE EXEMPT CERTIFIER Provide the name and phone number of the	this box if the applicant is a federal, state, or local government official or institution. Does not apply or Facility Name of Fee Exempt Institution. Be sure to enter the address of this exempt institution. The undersigned hereby certifies that the applicant named hereon is a federal, state or local government is exempt from payment of the application fee. Signature of certifying official (other than applicant) Date Print or type name and title of certifying official Make check payable to: Drug Enforcement Administration	rnment official or institution, one No. (required for verification)
FEE EXEMPT CERTIFIER Provide the name and phone number of the certifying official	this box if the applicant is a federal, state, or local government official or institution. Does not apply or Facility Name of Fee Exempt Institution. Be sure to enter the address of this exempt institution. The undersigned hereby certifies that the applicant named hereon is a federal, state or local government of the application fee. Signature of certifying official (other than applicant) Date Print or type name and title of certifying official Make check payable to: Drug Enforcement Administration See page 4 of instructions for important information.	rnment official or institution,
FEE EXEMPT CERTIFIER Provide the name and phone number of the certifying official SECTION 7 METHOD OF	this box if the applicant is a federal, state, or local government official or institution. Does not apply or Facility Name of Fee Exempt Institution. Be sure to enter the address of this exempt institution. The undersigned hereby certifies that the applicant named hereon is a federal, state or local government is exempt from payment of the application fee. Signature of certifying official (other than applicant) Date Print or type name and title of certifying official Make check payable to: Drug Enforcement Administration	on in Section 1. rnment official or institution, one No. (required for verification) Mail this form with payment to: DEA Headquarters
FEE EXEMPT CERTIFIER Provide the name and phone number of the certifying official SECTION 7 METHOD OF PAYMENT Check one form of	this box if the applicant is a federal, state, or local government official or institution. Does not apply or Facility Name of Fee Exempt Institution. Be sure to enter the address of this exempt institution. The undersigned hereby certifies that the applicant named hereon is a federal, state or local government is exempt from payment of the application fee. Signature of certifying official (other than applicant) Date Print or type name and title of certifying official Check Make check payable to: Drug Enforcement Administration See page 4 of instructions for important information. American Express Discover Master Card Visa	one No. (required for verification) Mail this form with payment to: DEA Headquarters ATTN: Registration Section/ODR P.O. Box 2639
FEE EXEMPT CERTIFIER Provide the name and phone number of the certifying official SECTION 7 METHOD OF PAYMENT Check one form of	this box if the applicant is a federal, state, or local government official or institution. Does not apply or Facility Name of Fee Exempt Institution. Be sure to enter the address of this exempt institution. The undersigned hereby certifies that the applicant named hereon is a federal, state or local government is exempt from payment of the application fee. Signature of certifying official (other than applicant) Date Print or type name and title of certifying official Check Make check payable to: Drug Enforcement Administration See page 4 of instructions for important information. American Express Discover Master Card Visa	one No. (required for verification) Mail this form with payment to: DEA Headquarters ATTN: Registration Section/ODR
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FEE EXEMPT CERTIFIER Provide the name and phone number of the certifying official SECTION 7 METHOD OF PAYMENT Check one form of payment only Sign if paying by credit card SECTION 8 APPLICANT'S	this box if the applicant is a federal, state, or local government official or institution. Does not apply or Facility Name of Fee Exempt Institution. Be sure to enter the address of this exempt institution. The undersigned hereby certifies that the applicant named hereon is a federal, state or local government and is exempt from payment of the application fee. Signature of certifying official (other than applicant) Date Print or type name and title of certifying official Check Make check payable to: Drug Enforcement Administration See page 4 of instructions for important information. American Express Discover Master Card Visa Credit Card Number Expiration Date Signature of Card Holder	on in Section 1. rnment official or institution, one No. (required for verification) Mail this form with payment to: DEA Headquarters ATTN: Registration Section/ODR P.O. Box 2639 Springfield, VA 22152-2639
FEE EXEMPT CERTIFIER Provide the name and phone number of the certifying official SECTION 7 METHOD OF PAYMENT Check one form of payment only Sign if paying by credit card	this box if the applicant is a federal, state, or local government official or institution. Does not apply or Facility Name of Fee Exempt Institution. Be sure to enter the address of this exempt institution. The undersigned hereby certifies that the applicant named hereon is a federal, state or local government of the application fee. Signature of certifying official (other than applicant) Date Print or type name and title of certifying official Check Make check payable to: Drug Enforcement Administration See page 4 of instructions for important information. American Express Discover Master Card Visa Credit Card Number Expiration Date Signature of Card Holder Printed Name of Card Holder	one No. (required for verification) Mail this form with payment to: DEA Headquarters ATTN: Registration Section/ODR P.O. Box 2639 Springfield, VA 22152-2639 FEE IS NON-REFUNDABLE

WARNING: 21 USC 843(d), states that any person who knowingly or intentionally furnishes false or fraudulent information in the application is subject to a term of imprisonment of not more than 4 years, and a fine under Title 18 of not more than \$250,000, or both.

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SECTION 1. APPLICANT IDENTIFICATION - Information must be typed or printed in the blocks provided to help reduce data entry errors. A physical address is required in address line 1; a post office box or continuation of address may be entered in address line 2. Fee exempt applicant must list the address of the federal or state fee exempt institution.

Applicant must enter a valid social security number (SSN), or a tax identification number (TIN) if applying as a business entity. *Debt collection information is mandatory pursuant to the Debt Collection Improvement Act of 1996.*

The email address, point of contact, national provider id, date of birth, year graduated, and professional school are new data items that are used to facilitate communication or as required by inter-agency data sharing requirements. They are requested in order to facilitate communication or as required by inter-agency data sharing requirements.

Practitioner must enter one degree from this list: DDS, DMD, DO, DPM, DVM, or MD.

Mid-level practitioner must enter one degree from this list: DOM, HMD, MP, ND, NP, OD, PA, or RPH.

SECTION 2. BUSINESS ACTIVITY - Indicate only one. Practitioner or mid-level practitioner must enter the degree conferred, and are requested to enter the last professional school of matriculation and the year graduated.

Automated dispensing system (ADS) must provide current DEA registration number of parent retail pharmacy or hospital, and attach a **notarized** affidavit in accordance with 21 CFR Part 1301.17. Affidavit must include:

- 1. Name of parent retail pharmacy or hospital and complete address
- 2. Name of Long-term Care (LTC) facility and complete address
- 3. Permit or license number(s) and date issued of State certification to operate ADS at named LTC facility
- 4. Required Statement:
 - This affidavit is submitted to obtain a DEA registration number. If any material information is false, the Administrator may commence proceedings to deny the application under section 304 of the Act (21 U.S.C. 8224(a)). Any false or fraudulent material information contained in this affidavit may subject the person signing this affidavit, and the named corporation/partnership/business to prosecution under section 403 of the Act (21 U.S.C 843).
- 5. Name of corporation operating the retail pharmacy or hospital
- 6. Name and title of corporate officer signing affidavit
- 7. Signature of authorized officer

SECTION 3. DRUG SCHEDULES - Applicant should check all drug schedules to be handled. However, applicant must still comply with state requirements; federal registration does not overrule state restrictions. Check the order form box only if you intend to purchase or to transfer schedule 2 controlled substances. Order forms will be mailed to the registered address following issuance of a Certificate of Registration. The following list of drug codes are examples of controlled substances for narcotic and non-narcotic schedules 2, 3, 4, and 5. Refer to the CFR for a complete list of basic classes.

SCHEDULE 2 NARCOTIC	BASIC CLASS	SCHEDULE 3 NARCOTIC	BASIC CLASS	SCHEDULE 4	BASIC CLASS
Alphaprodine (Nisentil)	9010	Buprenorphine (Buprenex, Temgesic, Subutex	9064	Alprzolam (Xanax)	2882
Anileridine (Leritine)	9020	Codeine combo product up to 90 mg/du (Empirin)	9804	Barbital (Veronal, Plexonal, Barbitone)	2145
Cocaine (Methyl Benzoylecgonine)	9041	Dihydrocodeine combo prod 90 mg/du (Compal)	9807	Chloral Hydrate (Noctec)	2465
Codeine (Morphine methyl ester)	9050	Ethylmorphine combo product 15 mg/du	9808	Chlordiazepoxide (Librium, Libritabs)	2744
Dextropropoxyphene (bulk)	9273	Hydrocodone combo product (Lorcet, Vicodin)	9806	Clorazepate (Tranxene)	2768
Diphenoxylate	9170	Morphine combo product 50 mg/100ml or gm	9810	Dextropropoxyphene du (Darvon)	9278
Diprenorphine (M50-50)	9058	Opium combo product 25 mg/du (Paregoric)	9809	Diazepam (Valium, Diastat)	2765
Ethylmorphine (Dionin)	9190	SCHEDULE 3 NON-NARCOTIC	BASIC CLASS	Diethylpropion (Tenuate, Tepanil)	1610
Etorphine Hydrochloride (M-99)	9059	Anabolic Steroids	4000	Difenoxin 1mg/25ug atropine SO4/du (Motofen)	9167
Glutethimide (Doriden, Dorimide)	2550	Benzphetamine (Didrex, Inapetyl)	1228	Fenfluramine (Pondimin, Dexfenfluramine)	1670
Hydrocodone (Dihydrocodeinone)	9193	Butalbital (Fiorinal, Butalbital w/aspirin)	2100/2165	Flurazepam (Dalmane)	2767
Hydromorphone (Dialudid)	9150	Dronabinol in sesame oil w/soft gelatin capsule	7369	Halazepam (Paxipam)	2762
Levo-alphacetylmethadol (LAAM)	9648	Gamma Hydroxbutyric Acid preps (Zyrem)	2012	Lorazepam (Ativan)	2885
Levorphanol (Levo-Dromoran)	9220	Ketamine (Ketaset)	7285	Mazindol (Sanorex, Mazanor)	1605
Meperidine (Demerol, Mepergan)	9230	Methyprylon (Noludar)	2575	Mebutamate (Capla)	2800
Methadone (Dolophine, Methadose)	9250	Pentobarbital suppository du & noncontrolled active ingred. (FP-3, WANS)	2271	Meprobamate (Miltown, Equanil)	2820
Morphine (MS Contin, Roxanol)	9300	Phendimetrazine (Plegine, Bontril, Statobex	1615	Methohexital (Brevital	2264
Opium, powdered	9639	Secobarbital suppository du & noncontrolled active ingredients	2316	Methylphenobarbital (Mebaral)	2250
Opium, raw	9600	Thiopental (Pentothal)	2100/2329	Midazolam (Versed)	2884
Oxycodone (Oxycontin, Percocet)	9143	Vinbarbital (Delvinal)	2100/2329	Oxazepam (Serax, Serenid-D))	2835
Oxymorphone (Numorphan)	9652			Paraldehyde (Paral)	2585
Opium Poppy / Poppy Straw	9650	SCHEDULE 5	BASIC CLASS	Pemoline (Cylert)	1530
Poppy Straw Concentrate	9670	Codeine Cough Preparation (Cosanyl, Pediacof)	9050	Pentazocine (Talwin, Talacen)	9709
Thebaine	9333	Difenoxin Preparation (Motofen)	9167	Phenobarbital (Luminal, Donnatal)	2285
SCHEDULE 2 NON-NARCOTIC	BASIC CLASS	Dihydrocodeine Preparation (Cophene-S)	9120	Phentermine (Ionamin, Fastin, Zantryl)	1640
Amobarbital (Amytal, Tuinal)	2125	Diphenoxylate Preparation (Lomotil, Logen)	9170	Prazepam (Centrax)	2764
Amphetamine (Dexedrine, Adderall)	1100	Ethylmorphine Preparation	9190	Quazepam (Doral)	2881
Methamphetamine (Desoxyn)	1105	Opium Preparation (Kapectolin PG)	9809	Temazepam (Restoril)	2925
Methylphenidate (Concerta, Ritalin)	1724			Triazolam (Halcion)	2887
Pentobarbital (Nemutal)	2270			Zolpidem (Ambien, Ivadal, Stilnox)	2783
Phencyclidine (PCP)	7471				
Phenmetrazine (Preludin)	1631				
Phenylacetone	8501				
Secobarbital (Seconal)	2315				

Form - 224 APPLICATION FOR REGISTRATION - CONTINUED -

SECTION 4. STATE LICENSE(S) - Federal registration by DEA is based upon the applicant's compliance with applicable state and local laws. Applicant should contact the local state licensing authority prior to completing this application. If your state requires a separate controlled substance number, provide that number on this application.

SECTION 5. LIABILITY - Applicant must answer all four questions for the application to be accepted for processing. If you answer "Yes" to a question, provide an explanation in the space provided. If you answer "Yes" to several of the questions, then you must provide a separate explanation describing the date, location, nature, and result of each incident. If additional space is required, you may attach a separate page.

SECTION 6. EXEMPTION APPLICATION FEE - Exemption from payment of application fee is limited to federal, state or local government official or institution. The applicant's superior or agency official (other than the applicant) must be provided. The address of the fee exempt institution must appear in Section 1.

SECTION 7. METHOD OF PAYMENT - Indicate the desired method of payment. Make checks payable to "Drug Enforcement Administration". Third-party checks or checks drawn on foreign banks will not be accepted. FEES ARE NON-REFUNDABLE.

SECTION 8. APPLICANT'S SIGNATURE - Applicant MUST sign in this section or application will be returned. Card holder signature in section 7 does not fulfill this requirement.

Notice to Registrants Making Payment by Check

Authorization to Convert Your Check: If you send us a check to make your payment, your check will be converted into an electronic fund transfer. "Electronic fund transfer." is the term used to refer to the process in which we electronically instruct your financial institution to transfer funds from your account to our account, rather than processing your check. By sending your completed, signed check to us, you authorize us to copy your check and to use the account information from your check to make an electronic fund transfer from your account for the same amount as the check. If the electronic fund transfer cannot be processed for technical reasons, you authorize us to process the copy of your check.

Insufficient Funds: The electronic funds transfer from your account will usually occur with 24 hours, which is faster than a check is normally processed. Therefore, make sure there are sufficient funds available in your checking account when you send us your check. If the electronic funds transfer cannot be completed because of insufficient funds, we may try to make the transfer up to two more times.

Transaction Information: The electronic fund transfer from your account will be on the account statement you receive from your financial institution. However, the transfer may be in a different place on your statement than the place where your checks normally appear. For example, it may appear under "other withdrawals" or "other transactions." You will not receive your original check back from your financial institution. For security reasons, we will destroy your original check, but we will keep a copy of the check for record-keeping purposes.

Your Rights: You should contact your financial institution immediately if you believe that the electronic fund transfer reported on your account statement was not properly authorized or is otherwise incorrect. Consumers have protections under Federal law called the Electronic Fund Transfer Act for an unauthorized or incorrect electronic fund transfer.

ADDITIONAL INFORMATION

No registration will be issued unless a completed application has been received (21 CFR 1301.13).

In accordance with the Paperwork Reduction Act of 1995, no person is required to respond to a collection of information unless it displays a valid OMB control number. The OMB number for this collection is 1117-0014. Public reporting burden for this collection of information is estimated to average 12 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information.

The Debt Collection Improvements Act of 1996 (31 U.S.C. §7701) requires that you furnish your Taxpayer Identification Number (TIN) or Social Security Number (SSN) on this application. This number is required for debt collection procedures if your fee is not collectible.

PRIVACY ACT NOTICE: Providing information other than your SSN or TIN is voluntary; however, failure to furnish it will preclude processing of the application. The authorities for collection of this information are §§302 and 303 of the Controlled Substances Act (CSA) (21 U.S.C. §§822 and 823). The principle purpose for which the information will be used is to register applicants pursuant to the CSA. The information may be disclosed to other Federal law enforcement and regulatory agencies for law enforcement and regulatory purposes, State and local law enforcement and regulatory agencies for law enforcement and regulatory purposes, and persons registered under the CSA for the purpose of verifying registration. For further guidance regarding how your information may be used or disclosed, and a complete list of the routine uses of this collection, please see the DEA System of Records Notice "Controlled Substances Act Registration Records" (DEA-005), 52 FR 47208, December 11, 1987, as modified.

Your Local **DEA Office**

CONTACT INFORMATION

All offices are listed on web site (800, 877, and 888 are toll-free)

INTERNET

www.deadiversion.usdoj.gov

TELEPHONE

HQ Call Center (800) 882-9539

WRITTEN INQUIRIES:

DEA

Attn: Registration Section/ODR P.O. Box 2639

Springfield, VA 22152-2639