Reset Form

APPLICATION FOR INDIANA CONTROLLED SUBSTANCES REGISTRATION (CSR) FOR PRACTITIONERS

State Form 34617 (R17 / 6-15)
Approved by State Board of Accounts, 2015

PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
www.pla.IN.gov

* Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory and this record cannot be processed without it.

INSTRUCTIONS: Please type or print all information.

FOR OFFICE USE ONLY		
CSR number	Date of issuance (*month, day, year*)	
Receipt number	Application fee	Date fee paid (*month, day, year*)

DO NOT WRITE ABOVE THIS LINE

PRACTITIONERS

(Please check one box)
☐ Dentist ☐ Physician ☐ Osteopathic Physician ☐ Podiatrist ☐ Veterinarian ☐ Advanced Practice Nurse ☐ Physician Assistant ☐ Optometrist

Name of practitioner		Specialty	
Telephone number ( )	Professional license number	Date of birth (*month, day year*)	Social Security number *
Name of Facility *(if applicable)*		E-mail address	
Indiana practice address *(number and street [may **not** be a PO Box], city, state, and ZIP code)*			

Drug schedules: *(Check all applicable)*
☐ 1 ☐ 2 ☐ 2 Narcotic ☐ 3 ☐ 3 Narcotic ☐ 4 ☐ 4 Limited Practice - Tramadol Only (Optometrist Only) ☐ 5

If your answer is **Yes** to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a registration issued pursuant to this application.

1. Has there been an occasion where you have not maintained effective controls against diversion of controlled substances into other than legitimate medical, scientific, or industrial channels? ☐ Yes ☐ No
2. Has there been an occasion where you have not been in complete compliance with all state and local laws pertaining to controlled substances? ☐ Yes ☐ No
3. Have you been convicted, pled guilty, or pled *nolo contendere,* under any federal or state laws relating to any controlled substances that has *not* been expunged under IC 35-38-9? ☐ Yes ☐ No
4. Have you had any action, discipline, revocation, or surrender of your Drug Enforcement Registration or entered into any settlement or Memorandum of Understanding (MOU) with respect to said registration? ☐ Yes ☐ No
5. Have you had any action, discipline or revocation or surrender of any professional license in any jurisdiction related to controlled substances? ☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of practitioner	Date (*month, day, year*)