

American Health Service DBA Med-Vet International

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Mettawa IL, 60045
Phone: 800-544-7521 Fax:800-204-2177



Controlled Substance Application

DEA Registration Information

Customer Type: Veterinary Podiatry Dental Other _____
 Practitioner _____ Teaching Inst _____ Humane Society _____
 Researcher _____ Wholesaler _____ Other _____
 DEA Registration Name: _____
 DEA Registration Number: _____
 DEA Registration Number Schedules: 2 2N 3 3N 4 5
 DEA Registration Number Exp Date: _____
 DEA Registered Address: _____

Registered State Licenses/Registrations

State _____ Lic# _____ Type: _____ Exp: _____
 State _____ Lic# _____ Type: _____ Exp: _____
 State _____ Lic# _____ Type: _____ Exp: _____
 State _____ Lic# _____ Type: _____ Exp: _____

Business Information

Business Type: Sole Proprietor Partnership Corporation State of Incorporation _____
 Corporate Officers: _____
 Name: _____
 Address: _____
 Phone Number: _____
 Change of ownership in the last 5 years? Yes No
 Owner a licensed practitioner? Yes No
 Number of practitioners at registered location: _____

Registered Location Practitioners Information

Name _____ DEA# _____ Schedules: _____ Exp: _____
 Name _____ DEA# _____ Schedules: _____ Exp: _____
 Name _____ DEA# _____ Schedules: _____ Exp: _____
 Name _____ DEA# _____ Schedules: _____ Exp: _____

Days and hour of business operations:

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|--------|---------|-----------|----------|--------|----------|--------|
| | | | | | | |

Questionnaire

Has any registrant at this location been inspected by any licensing authority, including DEA, in the past 5 years?(If yes, attach separate explanation of results and any corrective action.) Yes No

Is registrant or any practitioner/employee currently under investigation by any licensing Authority, including DEA? (If yes, attach explanation.) Yes No

Has registrant or any practitioner/employee had a license or registration denied, revoked or suspended by any licensing authority, including DEA? (If yes, attach explanation.) Yes No

Do you keep inventory of all stocks of controlled substances on hand at least every two years (biennial inventory) Yes No

How does the location store and secure controlled substances?

Does the storage location meet the security requirements of 21 CFR §1301.75(b)? Yes No

Is access to the controlled substances limited? Yes No

How many employees have access to controlled substances? _____

Employee(s) responsible for controlled substance purchasing, reporting, record-keeping, security:

Name: _____ Name: _____

Employee(s) authorized to sign DEA Forms 222 for Schedule II controlled substances on behalf of registrant:

Name: _____ Name: _____

Does employee authorized to sign DEA Forms 222 have a valid Power of Attorney on file at the registered location?Y/N(If yes, please provide copies of power of attorney.):_____

Average number of patients each day: _____ Average number of all prescriptions per day: _____

Average number of controlled substance per day: _____

Average controlled substances dispensed/administered per day (in dosage units): _____

Average non-controlled medications dispensed/administered each day (in dosage units): _____

List the top three most commonly dispensed/administered controlled substances: _____

List the top three most commonly prescribed controlled substances: _____

Do you treat out-of-state patients/N(If yes, how many?) _____

Average number of patients housed overnight per week (veterinary only): _____

Patient/subject mix. (veterinary/researcher only – total should equal 100%)

Companion: _____% Production: _____% Animal: _____% Equine: _____% Other: _____%

How often are controlled substances ordered? Daily Weekly Monthly Other: _____

When was your last inventory count?: _____

List all controlled drugs you anticipate ordering: _____

Percent of controlled substances (schedules II-V) and non-controlled substances (non-scheduled drugs) ordered from suppliers. (Total should equal 100%)

Controlled: _____% Non-Controlled: _____% Prescription OTC: _____%

Do you sell or transfer controlled substances to any other registrant? Yes No

Do you have a website? Yes No

If yes, please provide URL: _____

If yes, does the website offer pharmaceuticals to the general public? Yes No

Method of payment by patients/customers for controlled substance prescriptions (total should equal 100%):

Cash: _____% Insurance: _____% Medicaid/Medicare: _____% Check Credit Card: _____%
Electronic Transfer: _____%

Customer agrees and understands that American Health Service may provide a copy of this questionnaire to the DEA, other federal regulatory agencies and any state regulatory agency where appropriate.

Any controlled drug purchased will only be used for legitimate medical/research purposes only.

I certify that the information provided in this questionnaire is true and accurate to the best of my knowledge.

Print name and title of person who completed questionnaire: _____

Name (print) _____ Title _____ Date _____

Phone number _____

Signature _____ Date _____

| |
|--------------------------------|
| OFFICE USE ONLY |
| Date Received _____ |
| Date Reviewed _____ |
| Receiver _____ |
| Follow Up Date _____ |
| Follow Up Required? Y/N: _____ |
| Notes: _____ |