Reset Form

APPLICATION FOR INDIANA CONTROLLED SUBSTANCES REGISTRATION (CSR) FOR PRACTITIONERS

State Form 34617 (R21 / 1-21)

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

INSTRUCTIONS:

1. *The fee for this application is $60.00, payable to the Indiana Professional Licensing Agency, in accordance with 856 IAC 2-3-9(f).*
2. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
3. *All fees are non-refundable and non-transferable.*
4. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*
5. *If you currently hold a practitioner license in Indiana, you must also submit proof of completion of two (2) hours of continuing education in opioid prescribing / abuse, completed within the last two (2) years.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

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		Social Security number *
Date of birth (*month, day year*)	Professional license number	Telephone 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

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit 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.
A photostatic copy of this authorization has the same force and effect as the original.

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