NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services and Trauma Systems
Bureau of Narcotic Enforcement

# Application to be a Controlled Substance Agent for an ALS Agency

**Submit Application and all Required Attachments in Triplicate. Print or type neatly. Incomplete Applications will be Returned.**

☐ Initial ☐ Renewal

NYS EMS Agency Code | NYS EMS Cert. Expiration | 03C- Exp NYS Controlled Substance License

Agency Name | Federal Employer Number | Email

Physical Address of Principle Business (street and number) | City | State | Zip | County

Mailing Address (PO Box) | Business Phone ( ) - | ☐ Ambulance ☐ ALS First Responder Service Type

## Agency CEO/COO

Name | Title

Business Address | City, Town, Village | State | Zip

Mailing Address (PO Box) | Business Phone ( ) - | Home Phone ( ) -

## Controlled Substance Agent

Name | NYS EMT No. and Level (CC or P) | NYS EMT Expiration Date | Pharmacist Lic. No.

Street Address | City, Town, Village | State | Zip

Mailing Address (PO Box) | Best Phone H/W/C ( ) - | E-mail

## Medical Directors Affirmation

I have read and understand the content of 80.136 and agree to act as the agency's Medical Director. I understand my responsibilities relative to this application and hereby approve this agency's use of controlled substances under my medical direction.

Name of Physician Medical Director | Signature of Physician Medical Director | Date

## Part 80 Controlled Substances Applicant Certification

By Signing this application I certify that:

1. I have read and understand the contents and responsibilities of public Health Law Articles 30 and 33, the State EMS code (10NYCRR (art. 800) and Controlled Substances Regulations (10NYCRR Part80)
2. All information is correct and true
3. I or any named owner or responsible individual under the provisions of this part have never been convicted of a felony.
4. I accept the responsibilities as provided in 80.136(k)
5. I will insure all provisions and requirement s of the part are understood ad implemented by any person under my charge.
6. I will instruct all persons under my charge with their responsibilities with regard to storage, access, safeguarding of controlled substances and the reporting of any misuse or diversion.
7. I understand that any misrepresentation or falsification of this application is grounds for annulment, suspension, limiting or revocation of this article 33 license and may make me and the EMS Agency subject to further action by the New York State Department of Health.

Name of Agency CEO/COO | Signature of CEO/COO | Date

Name of Agent | Signature of Agent | Date

## Notary Public

Affirmation and Acknowledgement for Agent

## For DOH Use Only

EMS Approved Date

BCS Approved Date

## Send completed application to:

New York State Department of Health
Bureau of Emergency Medical Services and Trauma Systems
875 Central Avenue, Albany, NY 12206

Telephone 518-402-0996