NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Narcotic Enforcement

Notification of Discontinuance and Change of Participation

Pursuant to Drug Take Back Regulation Title 10 NYCRR Section 60-4.7(c) a manufacturer must notify the Department in writing upon (1) the manufacturer's discontinuance of participation in a drug take back program; (2) the manufacturer's changing of participation from one drug take back program to another; and (3) discontinuance of the sale of the manufacturer's covered drugs in the state within 15 days of the date of the applicable action. **Please use this form to make the required notifications to the Department.**

☐ **Discontinuance of Participation in a Drug Take Back Program**

Date of Discontinuance:

Manufacturer

Legal Name: _____

Contact Name: _____

Phone: _____ E-mail: _____

Mailing Address

Street Address 1: _____

Street Address 2: _____

City: _____ State: _____ Zip Code: _____ Country: _____

FDA Labeler Code, if applicable: _____

DEA Number, if applicable: _____

NYSED Registration Number, if applicable: _____

Manufacturer's Subsidiary (See page 3 to list additional subsidiaries)

Legal Name: _____

Contact Name: _____

Phone: _____ E-mail: _____

Mailing Address

Street Address 1: _____

Street Address 2: _____

City: _____ State: _____ Zip Code: _____ Country: _____

FDA Labeler Code, if applicable: _____

DEA Number, if applicable: _____

NYSED Registration Number, if applicable: _____

Drug Take Back Program

Organization Name: _____

Contact Name: _____

Phone: _____ E-mail: _____

Reason(s) for Discontinuance:

☐ Discontinuance of the Sale of Covered Drugs in New York State

☐ Other Reason for Discontinuance (please explain)

☐ **Change of Participation from One Drug Take Back Program to Another**

Date of Change:

Manufacturer

Legal Name: _____

Contact Name: _____

Phone: _____ E-mail: _____

Mailing Address

Street Address 1: _____

Street Address 2: _____

City: _____ State: _____ Zip Code: _____ Country: _____

FDA Labeler Code, if applicable: _____

DEA Number, if applicable: _____

NYSED Registration Number, if applicable: _____

Manufacturer's Subsidiary (See page 3 for additional subsidiaries)

Legal Name: _____

Contact Name: _____

Phone: _____ E-mail: _____

Corporate Mailing Address

Street Address 1: _____

Street Address 2: _____

City: _____ State: _____ Zip Code: _____ Country: _____

FDA Labeler Code, if applicable: _____

DEA Number, if applicable: _____

NYSED Registration Number, if applicable: _____

Former Drug Take Back Program

Organization Name: _____

Contact Name: _____

Phone: _____ E-mail: _____

Current Drug Take Back Program

Organization Name: _____

Contact Name: _____

Phone: _____ E-mail: _____

Signature

I, the undersigned, hereby certify under penalties of perjury, that the information stated herein is true, complete, and accurate to the best of my knowledge. False statements made here in are punishable as a class A misdemeanor pursuant to §210.45 of the Penal Law.

Corporate Officer/Owner Name: _____

Original Signature: _____ Date: _____

Title: _____

Submission

E-mail completed form(s)to the New York State Department of Health, Bureauof Narcotic Enforcement: dtb@health.ny.gov

Manufacturer's Subsidiary

Legal Name: ______________________________

Contact Name: ______________________________

Phone: ______________ E-mail: ______________________________

Corporate Mailing Address

Street Address 1: ______________________________

Street Address 2: ______________________________

City: ______________ State: ________ Zip Code: ________ Country: ______________

FDA Labeler Code, if applicable: ______________________________

DEA Number, if applicable: ______________________________

NYSED Registration Number, if applicable: ______________________________

Manufacturer's Subsidiary

Legal Name: ______________________________

Contact Name: ______________________________

Phone: ______________ E-mail: ______________________________

Corporate Mailing Address

Street Address 1: ______________________________

Street Address 2: ______________________________

City: ______________ State: ________ Zip Code: ________ Country: ______________

FDA Labeler Code, if applicable: ______________________________

DEA Number, if applicable: ______________________________

NYSED Registration Number, if applicable: ______________________________

Manufacturer's Subsidiary

Legal Name: ______________________________

Contact Name: ______________________________

Phone: ______________ E-mail: ______________________________

Corporate Mailing Address

Street Address 1: ______________________________

Street Address 2: ______________________________

City: ______________ State: ________ Zip Code: ________ Country: ______________

FDA Labeler Code, if applicable: ______________________________

DEA Number, if applicable: ______________________________

NYSED Registration Number, if applicable: ______________________________

Manufacturer's Subsidiary

Legal Name: ______________________________

Contact Name: ______________________________

Phone: ______________ E-mail: ______________________________

Corporate Mailing Address

Street Address 1: ______________________________

Street Address 2: ______________________________

City: ______________ State: ________ Zip Code: ________ Country: ______________

FDA Labeler Code, if applicable: ______________________________

DEA Number, if applicable: ______________________________

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