

# RENEWAL/CHANGE IOWA CONTROLLED SUBSTANCES REGISTRATION APPLICATION

Please type or print clearly. Change as necessary.

1 APPLICATION FOR:  Renewal  Change \_\_\_\_\_  
*Specify*

STATE CSA REGISTRATION NO.: \_\_\_\_\_  
EXPIRATION DATE (determined by Board): \_\_\_\_\_

REGISTRATION FEE: \$90.00

Penalty fee of \$90 imposed if renewed after expiration.

Submit check or money order payable to  
Iowa Board of Pharmacy – **DO NOT SEND CASH.**

2 REGISTRANT/APPLICANT NAME AND  
MAILING ADDRESS if other than practice address  
*(alternate address not available for pharmacy or hospital registration)*

NAME \_\_\_\_\_  
Last Name, First Name, Middle Initial, Professional Abbreviation

ADDRESS \_\_\_\_\_  
*(max. 2 lines-30 characters/line)*

CITY, STATE, ZIP \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

3 IOWA PRACTICE OR BUSINESS ADDRESS

*(location of office or other practice setting in Iowa – not PO Box)*

NAME \_\_\_\_\_  
Last Name, First Name, Middle Initial, Professional Abbreviation

ADDRESS \_\_\_\_\_  
*(max. 3 lines-30 characters/line)*

CITY, STATE, ZIP \_\_\_\_\_

COUNTY \_\_\_\_\_

4 BUSINESS PHONE (\_\_\_\_\_) \_\_\_\_\_

5 BUSINESS ACTIVITY \_\_\_\_\_

6 FEDERAL DEA # \_\_\_\_\_

7 IOWA PROFESSIONAL LICENSE # \_\_\_\_\_

8 SCHEDULES -- Check schedules in which you intend to handle (including prescribe) ANY controlled substances.

Schedule I  Schedule II  Narcotic Schedule II  Nonnarcotic Schedule III  Narcotic Schedule III  Nonnarcotic Schedule IV  Schedule V

*(Refer to <https://pharmacy.iowa.gov/licensureregistration/controlled-substance-applications> for description of drug schedules.)*

9 RESPONSIBLE INDIVIDUAL *(Whose signature is authorized on Federal Controlled Substances Order Form 222)*

a) \_\_\_\_\_  
*Name Title*

b) IF APPLICANT IS: PRACTITIONER, indicate Medical Degree \_\_\_\_\_ or RESEARCHER, indicate Degree \_\_\_\_\_

10 ALL APPLICANTS MUST ANSWER THE FOLLOWING *[answer 10a) or 10b) as appropriate]:*

a) IF APPLICANT IS AN INDIVIDUAL, has the applicant ever been convicted of a felony in connection with controlled substances under any State or Federal law; ever surrendered (in lieu of disciplinary action) or had a CSA or DEA registration revoked, suspended, or denied; ever had a professional license revoked, suspended, or otherwise disciplined for issues related to controlled substances; or are you aware of any pending investigations relating to such issues? \_\_\_\_\_

b) IF APPLICANT IS A CORPORATION, PARTNERSHIP, ASSOCIATION, OR PHARMACY, has any officer, partner, stockholder, or proprietor been convicted of a felony in connection with controlled substances under any State or Federal law, or ever surrendered or had a CSA registration revoked, suspended, or denied? \_\_\_\_\_

c) IF YOU ANSWERED 'YES' TO ANY OF THESE QUESTIONS (10a or 10b), include a statement using the space provided on the REVERSE of this page.

d) IF CONTROLLED SUBSTANCES WERE LOST OR STOLEN during the past two years, indicate the number of occurrences next to the applicable reason. If none, check here.

THEFT \_\_\_\_\_ ARMED ROBBERY \_\_\_\_\_ MYSTERIOUS DISAPPEARANCE \_\_\_\_\_ LOST IN TRANSIT \_\_\_\_\_

11 IF APPLICANT IS INDIVIDUAL: Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

**ANY INDIVIDUAL PRACTITIONER WHO ADMINISTERS OR DISPENSES CONTROLLED SUBSTANCES AT ANY LOCATION WITHIN IOWA OTHER THAN SHOWN ABOVE (EXCEPT LICENSED HOSPITALS) MUST OBTAIN A SEPARATE REGISTRATION FOR EACH SUCH LOCATION.**

REMIT TO: IOWA BOARD OF PHARMACY  
CONTROLLED DRUG DIVISION  
400 S.W. EIGHTH STREET, SUITE E  
DES MOINES, IOWA 50309-4688  
PHONE: (515) 281-5944

Information provided on  
this application may be  
disclosed pursuant to  
657 IAC Chapter 14.

I hereby swear under penalty of perjury that the information provided in this application is true and correct. I understand that failure to provide complete and truthful information may constitute grounds for revocation or other disciplinary sanctions against my registration.

SIGN  
HERE 

\_\_\_\_\_  
*Signature of Applicant or Authorized Individual (Pharmacist in Charge if pharmacy application)* \_\_\_\_\_ *Date*  
**INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED AND WILL BE RETURNED TO THE APPLICANT**

**10c) EXPLANATION FOR ANSWERING 'YES' TO QUESTION 10a) OR QUESTION 10b):**

Applicants who answered 'YES' to any of the questions in 10a) or 10b) are required to submit a statement explaining such response. The space below is available for this purpose. If necessary, attach additional pages and include documents relating to the issue(s) if such documents have not previously been provided to this Board. The statement must be signed by the applicant on the line provided below.

---

*Clearly print or type name here -- sign below.*

**I hereby swear under penalty of perjury** that the information provided in and with this application is true and correct. I understand that failure to provide complete and truthful information may constitute grounds for revocation or other disciplinary sanctions against my registration.

**SIGN  
HERE**



---

*Signature of Applicant*

---

*Date*

