

Notification of Intent to Use Schedule III, IV, or V Opioid Drugs for the Maintenance and Detoxification Treatment Opiate Addiction under 21 USC § 823(g)(2)	Form Approved: 0930-2334 Expiration Date: 07/31/2015 See OMB Statement on Second Page DATE OF SUBMISSION
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Note: Notification is required by § 303(g)(2), Controlled Substance Act (21 USC § 823 (g)(2)). See Instruction below.

1a. NAME OF PRACTITIONER

 First Middle Last Suffix

b. State Medical License Number **c. DEA Registration Number**
 State: _____

2. ADDRESS OF PRIMARY LOCATION <i>(Include Zip Code)</i> <i>(See instruction below)</i> Address: _____ City: _____ State: _____ Zip Code: _____	3. TELEPHONE NUMBER <i>(Include Area Code)</i> _____ 4. FAX NUMBER <i>(Include Area Code)</i> _____ 5. EMAIL ADDRESS <i>(required for submission of this form)</i> _____
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6. PURPOSE OF NOTIFICATION *(See instruction below)*

New Notification New Notification, with the intent of immediately facilitate treatment of an individual (one) patient
 Second notification of need and intent to treat up to 100 patients

7. CERTIFICATION OF USE OF NARCOTIC DRUGS UNDER THIS NOTIFICATION

I certify that I will only Schedule III, IV, or V drugs or combinations of drugs that have been approved by the FDA for use in maintenance or detoxification treatment and that have not been subject of an adverse determination.

8. CERTIFICATION OF QUALIFYING CRITERIA

I certify that I meet at least one of the following criteria and am therefore a qualifying physician *(Check and provide copies of documentation for all that apply)*:

Subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties
 Addiction certification from the American Society of Addiction Medicine
 Subspecialty board certification in addiction medicine form the American Osteopathic Association
 Completion of not less than eight hours of training for the treatment and management of opioid-dependent patients provided by the following organization(s):

American Society of Addiction Medicine
 American Academy of Addiction Psychiatry
 American Medical Association
 American Osteopathic Association
 American Psychiatric Association
 Date and location of training (Use "Web" for city if web training was received):
 On _____ (mm/dd/yyyy) in _____ (City), _____ (State), _____

Participation as an investigator in one or more clinical trials leading to the approval of a Schedule III, IV, or V narcotic drug for maintenance or detoxification treatment
 State medical licensing board-approved experience or training in the treatment and management of opioid-dependent patients
 Other *(specific)*

Additional Descriptions:

9. CERTIFICATION OF CAPACITY

I certify that I have the capacity to refer patients for appropriate counseling and other appropriate ancillary services.

