**L**ouisiana **S**tate **B**oard of **M**edical **E**xaminers

630 Camp Street, New Orleans, LA 70130

(504) 568-6820

**APPLICATION FOR REGISTRATION AS A DISPENSING PHYSICIAN**

**READ CAREFULLY AND TAKE NOTICE:** This application and any subsequently issued license, permit, certificate, or other authority to practice in the State of Louisiana are subject to all Louisiana laws and administrative rules governing the practice of medicine and allied health. A copy of the laws and rules can be found on the LSBME website. All applicants are hereby PLACED ON NOTICE that they are responsible for knowing the laws and rules and for complying with them. By submitting this application, you expressly acknowledge and agree that you are responsible for knowing and complying with the laws and administrative rules governing the practice of licensure for which you are applying.

**The Board may refuse to consider any application which is not complete in every detail and may, in its discretion, require a more detailed or complete response to any request for information set forth in this application as a condition to consideration of an application. The application shall be accompanied by a non-refundable fee of Seventy-Five Dollars ($75.00)**

**FILL IN ONLINE PRIOR TO PRINTING**

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| **Name: Last** | | | | | | **First** | | **Middle** | | | **Suffix (Sr., Jr.)** | | | **Suffix (MD/DO)** | | | |
| **DEA Number:** | | | | | | | **CDS Narcotics No.** | | | | | | | | | | |
| **Social Security Number** | | | | | | | **Date of Birth** | | | | | | | | | | |
| **Email Address** | | | | **Fax Number** | | | | | | **Cell Phone Number** | | | | | | | |
| **Addresses** | **Home Address** | **Street & Number** | | | | | | | **City** | | | | | | **State** | | |
| **Zip + 4** | | | **County/Parish** | | | | **Telephone (Area code, number).** | | | | | | | | |
| **Preferred Mailing Address** | **Street & Number or Post Office Box** | | | | | | | **City** | | | | | | **State** | | |
| **Zip + 4** | | | **County/Parish** | | | | **Telephone (Area code, #, Ext.)** | | | | **Pager Number** | | | | |
| **Professional Addresses: (DO NOT USE P.O. BOX NUMBERS) give number, street, suite number, city, state, Zip Code, and area code and telephone number for each location where you propose to dispense drugs, chemicals and medications. If a medical firm, state name of firm. (Attach additional pages as needed)**  **1.**  **2.**  **3.** | | | | | | | | | | | | | | | | |
| **List all other physician associates who practice in the locations at which you are applying to dispense medication.**  **Attach additional pages as needed.** | | |  | | | | | | | | | | | | | | |
| **Education and Training** | | | **MD/DO graduation date:**  **Residency Training Dates ( year only) From:       To:**  **Primary Specialty:       Board Certified:** **Yes** **No** | | | | | | | | | | | | | | |
| **Indicate the type of dispensing permit you are applying for :**  **(check one)** | | | **Legend Drugs Dispensing permit**  **OR**  **Legend and CDS Dispensing permit** | | | | | | | | | | | | | | |
| **List all medications proposed to be dispensed. Include brand or generic name, CDS schedule, dosage, quantity.**  **Attached additional pages as needed.** | | |  | | | | | | | | | | | | | | |
| **ANSWER THE FOLLOWING QUESTIONS:**  **IF ANSWER IS YES, ATTACH A DETAILED EXPLANATION** | | | | | | | | | | | | | | | | | |
| 1. Have you ever been convicted, whether upon verdict, judgment, or plea of guilty or *nolo contendere*, of any crime constituting a felony under the laws of the United States or of any state | | | | | | | | | | | | | **YES** | | | | **NO** |
|  | | | |  |
| 1. Have you ever been convicted, whether upon verdict, judgment, or plea of guilty or *nolo contendere*, of any crime and element of which is the manufacture, production, possession, use, distribution, sale, or exchange of any controlled substance | | | | | | | | | | | | |  | | | |  |
| 1. Have you ever within the five years preceding application for registration, abused or excessively used any medication, alcohol, or other substance which can produce physiological or psychological dependence or tolerance or which acts as a central nervous system stimulant or depressant. | | | | | | | | | | | | |  | | | |  |

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| **ACKNOWLEDGEMENTS** | | |
| 1. I have read and understand the rules on the Dispensing of Medication. | **YES** | **NO** |
|  |  |
| 2. I acknowledge I personally completed the online Dispensing Rules Course and Quiz. |  |  |
| 3. I acknowledge a physician is prohibited from delegating the dispensation and or labeling of medication to any medical personnel, including a  nurse/employee. |  |  |
| 4. I acknowledge that a Legend and CDS permit limits me to dispensing a single 48 hour supply of a CDS except as noted in the  rules, a seven day sample of Lyrica |  |  |

# *OATH OR AFFIRMATION OF APPLICANT*

I HEREBY swear or affirm that all statements made and information provided in or with this application are true, correct and complete; that I am the person named in the credentials herewith presented and that I am the original and lawful possessor of such documents; that the photograph submitted to LSBME is a true likeness of me and that it was taken within the last 60 days; that in consideration of the issuance to me of a license/certificate to practice in Louisiana, I swear that I shall observe and abide by the rules and regulations of dispensation of medications and I hereby agree that the violation of this oath shall constitute cause sufficient for the revocation of said license/certificate and surrender of the rights and privileges accorded me thereunder.

I HEREBY authorize all hospitals, institutions or organizations, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state or federal) to release to the Louisiana State Board of Medical Examiners any information, files or records requested by the Board. I further authorize Louisiana State Board of Medical Examiners to release to any such organization, individual or group having reasonable need therefore any information supplied to or obtained by the Board connection with my application or relative to the status of any license or certificate issued to me as a result of such application.

I CERTIFY under oath my acknowledgment and understanding that I am solely responsible for the proper and legitimate use of my DEA number for all controlled substance transactions. I will be present at any time that medication is dispensed from a registered dispensing location, and solely responsible for dispensing all medication and maintaining all invoices, orders, inventories, dispensing and other required records in the manner prescribed by the Board’s dispensing rules. By my subscription hereto, I acknowledge that I fully understand that failure to adhere to the Board’s dispensing rules may constitute violation of State and Federal law, subjecting me to criminal investigation and prosecution by State and Federal authorities, as well as action against my medical license by the Board.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name

**Subscribed and sworn to before me this \_\_\_\_\_\_\_\_\_\_\_\_\_day**

**of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_YEAR\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Notary Seal)**

**NOTARY PUBLIC**

**My commission expires\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**By submitting this application, I expressly acknowledge that I understand and agree I am responsible for knowing and complying with the laws and administrative rules governing the practice of licensure for which I am applying. A copy of which are available for my review on the LSBME website.** [**CLICK HERE TO READ THE RULES BY SELECTING YOUR LICENSE CATEGORY**](https://www.lsbme.la.gov/licensure/rules)**.**