

**\*\*PLEASE PRINT OR TYPE\*\***

APPLICANT INFORMATION			CONTACT INFORMATION	
Applicant Name			Contact Name	
Street			Title	
City	State	Zip	Telephone	
Telephone	County		Fax	
Class 3A License # (if applicable)			E-Mail	

EVENT INFORMATION				
<input type="checkbox"/> Household Event			<input type="checkbox"/> Institutional/Household Event	
Date of Event	Hours	Location Where Controlled Substances Will be Collected		
Law Enforcement Agency to be Present				
On-Site Law Enforcement Contact			On-Site Telephone	
On-Site Applicant Contact			On-Site Telephone	
<input type="checkbox"/> Law Enforcement will take possession of all pharmaceuticals (both controlled and non-controlled) <input type="checkbox"/> Law Enforcement will take possession of controlled substances only ( <b>Note: The participation of a licensed pharmacist is required</b> )				
On-Site Pharmacist (if applicable) (attach additional names/license # as necessary)			License #	

SUPPORTING DOCUMENTATION	
Attach the following documentation to the application:	
<input checked="" type="checkbox"/> An event plan which outlines the logistics of the event, including site and collection information and security arrangements. <input checked="" type="checkbox"/> A letter from the Department of Environmental Conservation granting a variance allowing for the disposal of pharmaceuticals surrendered in a solid waste incinerator. <input checked="" type="checkbox"/> A letter from the law enforcement agency to be present at the event, which includes a statement that the agency agrees to take possession of all controlled substances surrendered during the event, as well as a plan for their ultimate disposal.	

APPLICANT SIGNATURE (must be an original signature in ink)	
I hereby attest that I am authorized by the applicant to sign this application and that no controlled substances will be collected or surrendered without written authorization from the New York State Department of Health's Bureau of Narcotic Enforcement. Upon authorization, I attest that the applicant will comply with all requirements set forth by the Bureau of Narcotic Enforcement and that all activities will be conducted in accordance with Federal, state and local laws.	
Name	Title
Signature of Applicant (or Authorized Representative)	Date

Please return your completed application addressed to:

**New York State Department of Health  
Bureau of Narcotic Enforcement  
Riverview Center  
150 Broadway  
Albany, New York 12204**

Office Use Only	
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
Approved By	
Name	
Signature	
Date	