NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services and Trauma Systems
Bureau of Narcotic Enforcement

Application for ALS Agency to Engage in Controlled Substances Activity for Pre Hospital Care

Submit application and all required attachments in triplicate. Print or type neatly. Incomplete applications will be returned.

☐ Initial ☐ Renewal

NYS EMS Agency Code: ____ NYS EMS Cert. Expiration: ____ NYS Controlled Substance License: 03C- ____ Exp ____

Agency Name: ____ Federal Employer Number: ____

Physical Address of Principle Business (street and number): ____ City: ____ State: ____ Zip: ____ County: ____

Mailing Address (PO Box): ____ Business Phone: ( ) - ____ Service Type: ☐ Ambulance ☐ ALS First Responder

Organizational Structure (check one only) ☐ Proprietary ☐ Industrial ☐ Vol. Independent ☐ Hospital ☐ Governmental/ Municipal ☐ Vol. Fire Dept. ☐ Other ____

Type of Ownership (check one only) ☐ Individual ☐ Partnership ☐ Government ☐ Corporation

Name of Individual Owner, Partners, Corporation or Government Entity: ____

Level of service provided by Agency (check highest) ☐ EMT Critical Care ☐ EMT Paramedic

Agency CEO/COO

Name: ____ Title: ____

Business Address: ____ City, Town, Village: ____ State: ____ Zip: ____

Mailing Address (PO Box): ____ Business Phone: ( ) - ____ Home Phone: ( ) - ____

Controlled Substance Agent Appointed by Agency

Name: ____ NYS EMT No. and Level (CC or P): ____ NYS EMT Expiration Date: ____ Pharmacist Lic. No.: ____

Street Address: ____ City, Town, Village: ____ State: ____ Zip: ____

Mailing Address (PO Box): ____ Best Phone H/W/C: ( ) - ____ E-mail: ____

Agency Physician Medical Director

Name: ____ DEA Number: ____ NYS License No.: ____

Business Address: ____ City, Town, Village: ____ State: ____ Zip: ____

Mailing Address (PO Box): ____ Business Phone: ( ) - ____ Home Phone/Cell Phone: ( ) - ____

Organization Providing Medical Control to Agency (REMAC)

Name: ____ Contact Person: ____ Title: ____

Physical Location: ____ City, Town, Village: ____ State: ____ Zip: ____

Mailing Address: ____ Business Phone/Cell Phone: ( ) - ____

Contracting (Hospital,MD, Medical Suppler) Source of Controlled Substances

Name | Contact Person | Title

Physical Location | City, Town, Village | State | Zip

Mailing Address | Business Phone ( ) - | DEA Number

List of Addresses and Locations for each Authorized Stock and/or Substock of Controlled Substances

List of Attachments and Supporting Documents as Required

- ☐ Controlled Substance Plan (80.136.f.4)
- ☐ Controlled Substance Supplier Agreement
- ☐ Protocol(s) for Controlled Substance Administration
- ☐ Copy of Expiring CS License
- ☐ Agent Form(s)
- ☐ QA Plan for Controlled Substances (80.136.f.5)
- ☐ All Locally Developed Forms/Documents
- ☐ CS Semiannual Reports
- ☐ Check for $100.00 (unless exempt organization*)
- ☐ Roster of Participants

*Under provisions of section 3305.4 of PHL **municipalities** operating EMS agencies are exempt from the application fee.

Medical Directors Affirmation

I have read and understand the content of 80.136 and agree to act as the agency's Medical Director. I understand my responsibilities relative to this application and hereby approve this agency's use of controlled substances under my medical direction.

Name of Physician Medical Director | Signature of Physician Medical Director | Date

Part 80 Controlled Substances Applicant Certification

By Signing this application I certify that:

1. I have read and understand the contents and responsibilities of public Health Law Articles 30 and 33, the State EMS code (10NYCRR (art. 800) and Controlled Substances Regulations (10NYCRR Part80)
2. All information is correct and true
3. I or any named owner or responsible individual under the provisions of this part have never been convicted of a felony.
4. I accept the responsibilities as provided in 80.136(k)
5. I will insure all provisions and requirement s of the part are understood ad implemented by any person under my charge.
6. I will instruct all persons under my charge with their responsibilities with regard to storage, access, safeguarding of controlled substances and the reporting of any misuse or diversion.
7. I understand that any misrepresentation or falsification of this application is grounds for annulment, suspension, limiting or revocation of this article 33 license and may make me and the EMS Agency subject to further action by the New York State Department of Health.

Name of Agency CEO/COO

Signature of CEO/COO | Date

Notary Public

Affirmation and Acknowledgement of CEO/COO

For DOH Use Only

EMS	Approved	Date
BCS	Approved	Date

Send completed application to:

New York State Department of Health
Bureau of Emergency Medical Services and Trauma Systems
875 Central Avenue, Albany, NY 12206

Telephone 518-402-0996