

Semi-Annual Controlled Substance Inventory Form for EMS Agencies

Title 10 of New York State Rules and Regulations Part 80.136(j)(1) states: "Within 30 days of June 30 and December 31 of each year, the ALS Agency shall submit a report for that six month period to the Department signed by the agent which report shall include the following...". All agents and members of an ALS Agency are under a continuing duty to report immediately to the Department and the medical director any loss, theft, or diversion of controlled substances.

This report must be received at BNE and BEMS within 30 days of the end of reporting period

Semi-Annual Ending on: June 30 December 31 of year _____

Check box for correct semi-annual period

Agency Name			
Address Line 1		Address Line 2	
City	State	Zip	County
BNE Class 3C License #	NYS EMS Agency Code #	DEA Registrant Name	
CS Agent's Name		DEA Registrant Contact Name	
CS Agent's Telephone #		Contact's Telephone #	DEA Registration #
CS Agent's E-mail Address		Contact's E-Mail Address	

Use additional forms if reporting more than 5 controlled substance medications

CONTROLLED SUBSTANCE NAME	Fentanyl	Midazolam	Morphine	Ketamine	
Amount per ml (e.g. 1mg/ml)					
Last Periods Ending Inventory Amount (ml)					
Add total Amount Received (ml)					
Subtract Total Amount Utilized (ml)					
Subtract Total Amount Destroyed/Wasted (ml)					
Subtract Total Amount Returned to Pharmacy or Reverse Distributor (ml)					
*Subtract total Amount Lost (ml)					
Total Ending Inventory					
Physical Inventory Count (stocks plus sub-stocks)					
Total quantity carried in each sub-stock (e.g. 400 mcg)					

*** Form DOH – 2094 must accompany this report if there is any loss of controlled substances**

Comments (attach additional pages as needed) Any reports or findings of significant increases or decreases in CS medication administrations should be explained here as well as any known shortages of CS medications.

Controlled Substance Agent

I certify that on ____/____/____ I conducted a physical inventory on the controlled substances listed above. Any loss has been noted.

I affirm that all information contained on this form is true and correct, to the best of my knowledge, and that I will abide by all laws and regulations pertinent to controlled substances. False statements made herein are punishable as a Class A misdemeanor, pursuant to section 210.45 of the Penal Law.

Signature of Agent

Print Name

Date _____

Title _____

EMS Agency Medical Director and Agency CEO

I affirm that all information contained on this form is true and correct, to the best of my knowledge, and that I will abide by all laws and regulations pertinent to controlled substances. False statements made herein are punishable as a Class A misdemeanor, pursuant to section 210.45 of the Penal Law.

Signature of Medical Director

Print Name

Date _____

Title _____

Signature of CEO

Print Name

Date _____

Title _____

Submit completed form to both the Bureau of Narcotic Enforcement and the Bureau of EMS and Trauma

Bureau of Narcotic Enforcement

E-mail documents to:
narcotic@health.ny.gov

Or mail, only if necessary to:
Bureau of Narcotic Enforcement
Riverview Center
150 Broadway
Albany, NY 12204

Bureau of EMS and Trauma Systems

NYS DOH Bureau of EMS & Trauma
875 Central Avenue
Albany, NY 12206