

NEW YORK STATE DEPARTMENT OF HEALTH
 Bureau of Controlled Substances
 Bureau of Emergency Medical Services

**Controlled Substances
 Semi-Annual Report
 For EMS Agencies**

This report must be submitted pursuant to PHL Article 33 within 30 days of June 30 and December 31, each year. Retain a copy for your records.

Reporting Period 9 January 1- June 30, _____ 9 July 1 -- December 31, _____

| | | | | |
|------------------------|-----------------|---------------------|-----------|----------------|
| Agency Name | NYS-EMS ID No. | NYS-BCS License No. | | |
| Address | City | State | Zip | Business Phone |
| Name of DEA Registrant | DEA License No. | | Day Phone | |

| | Name of Controlled Substance | Name of Controlled Substance | Name of Controlled Substance |
|---|------------------------------|------------------------------|------------------------------|
| Dosage Form (mg/ unit) | | | |
| Total Quantity Received from DEA Registrant | | | |
| Total Quantity Administered & Wasted | | | |
| Total Quantity Lost | | | |
| Total Quantity Accounted from Records (Stock & Substocks) | | | |
| Physical Inventory Count (Stock & Substocks) | | | |

I certify that on _____ I conducted an actual physical inventory of the controlled substances listed above. Any loss or overage is explained on a separate attached report. I affirm that this is a true and accurate record of the controlled substance utilization by the above named agency.

 Name of Agent (print)

 Signature of Agent

 Date

 Name of CEO (print)

 Signature of CEO

 Date

Sent completed report by due date to: **New York State Department of Health, Bureau of Emergency Medical Services**
 433 River Street 6th Fl., Troy, NY 12180 Telephone 518-402-0996 x2