Washington State Department of Health

Controlled Substance Researcher Application Packet

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360-236-4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Pharmacy Quality Assurance
Commission Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the required forms.

☐ **Application Fee:** (This fee is non-refundable). You can check the online **fee page** for current fees.

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360-236-4700 if you do not have one.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state, and country where you were born.

Address: List your home address, including the city, state, zip code, county, and country.

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known by any other names. If you have a name change, you must notify the Department of Health in writing. You must include legal proof of this change. See **WAC 246-12-300**.

☐ **Research Information:**
Facility/Agency Name: Enter the agency's name as advertised on signs, brochures or Web site.

Uniform Business Identifier Number (UBI #): Enter your Washington State UBI #. All Washington State businesses must have UBI #s. City, county, and state government departments also have UBI #s.

Federal ID Number (FEIN #): Enter your Federal ID Number, if the business has been issued one.

Legal Owner/Operator Name: Enter the owner's name as it appears on the UBI/ Master Business License.

Physical Address: Enter the facility/agency's physical street location including city, state, zip and county.

Mailing Address: List the address we should use to send any information on your license. Be sure to include the city, state, zp code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change. See **WAC 246-12-310**.

Phone, Fax and Cell Numbers: Enter the facility's/agency's phone, fax and cell numbers, if you have them.

Email and Web Addresses: Enter the facility/agency email and Web addresses, if you have them.

☐ **2: Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3: Key Individuals:**
Enter research lab contact name, title, phone number, and email address.

☐ **4: Research Lab Information:**
Describe type of research to be performed.

List the controlled substances to be used.

List names of persons authorized to access controlled substances.

☐ **5: Applicant's Attestation:**
You must sign and date this for us to process the application.

Other Information:

- The application is considered incomplete if requested information is left blank. Write N/A or place a line through section instead of leaving blank.
- Certifications must be renewed every year prior to May 31 as provided in chapter **246-907-030(2)**. A courtesy renewal notice will be mailed to your address on record. You must keep your address current with us. Any renewal postmarked or presented to the department after midnight on the expiration date is late.

Information regarding the pharmacy program is available on our **Web site**.

Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue 0262010000

Controlled Substance Researcher Application

Please type or print clearly in blue or black ink. It is the responsibility of the applicant to submit all required supporting documentation. Failure to do so may result in a delay in processing your application.

Applying for:

☐ New Registration .....Current or previous state registration #: FX_____

☐ Business Name Change Only .....DEA registration # _____

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions)

Name	First	Middle	Last

Birth date (mm/dd/yyyy)	Place of Birth		
	City	State	Country

Home Address			
City	State	Zip Code	County
Home Phone (Enter 10 digit #)	Fax (Enter 10 digit #)		Cell (Enter 10 digit #)

Email Address:

Have you ever been known under any other name(s)? If yes, list name(s):

Will documents be received in another name? If yes, list name(s):

Research Lab Information

Facility/Agency Name (Business name as advertised on signs or Web site)			UBI #
Physical Address			
City	State	Zip Code	County
Facility Phone (Enter 10 digit #)		Fax (Enter 10 digit #)	
Mailing Address (If different than physical address)			
City	State	Zip Code	County

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ..... ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

   Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

   The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ..... ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ..... ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ..... ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? .. ☐ ☐

   Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

   To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction ..... ☐ ☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ..... ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ..... ☐ ☐
   b. Diverted controlled substances or legend drugs? ..... ☐ ☐
   c. Violated any drug law? ..... ☐ ☐
   d. Prescribed controlled substances for yourself? ..... ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? . ..... ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ..... ☐ ☐

9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ..... ☐ ☐

10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ..... ☐ ☐

3. Key Individuals (Research Lab Contact)

Name: _____ Title: _____

Phone # _____ Email: _____

4. Research Information

Describe type of research to be performed _____

_____

_____

_____

_____

_____

_____

_____

List the controlled substances to be used.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Names of persons authorized to access controlled substances.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

5. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws
(Print Applicant Name Clearly)

of the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____at _____
(mm/dd/yyyy) (City, State)

by:_____
(Original Signature of Applicant)

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RCW/WAC Online Web Site and Links

RCW/WAC Links

Uniform Disciplinary Act.....RCW 18.130

Administrative Procedure Act .....RCW 34.05

Administrative procedures and requirements.....WAC 246-12

Pharmacy Law.....RCW 18.64

Pharmacy Rules—Regulations Implementing
the Uniform Controlled Substances Act.....WAC 246-887

Uniform Controlled Substances Act.....RCW 69.50

On-Line

AIDS Training Resources ..... Reference Page

Pharmacy Quality Assurance Commission..... Web Page

List-Serv

To receive emails regarding important pharmacy information,
please join our interested parties at.....List-Serv