



Arizona Board of Osteopathic Examiners In Medicine and Surgery

9535 E. Doubletree Ranch Road Ste 200, Scottsdale, AZ 85258-5572

Ph : 480-657-7703 | Fx: 480-657-7715 | www.azdo.gov | questions@azdo.gov

DISPENSING PHYSICIAN REGISTRATION ANNUAL RENEWAL FORM

If you had a Dispensing Registration and are NOT renewing it this year, YOU MUST disclose IN WRITING how you disposed of your inventory pursuant to A.R.S. §32-1871(f) using the Inventory Disposal Form on our website.

AZ law (A.R.S. §32-1871) requires that you register with the Board if you dispense prescription-only drugs or devices (excluding samples) to your patients from your office, clinic, or practice location. This law applies only to doctors practicing in Arizona, not to doctors practicing out of state. It does not apply to doctors who may work in large HMO practices or buildings that also have a pharmacy on-site, as long as that pharmacy has a licensed pharmacist and is under the jurisdiction of the AZ Pharmacy Board.

You do not need a dispensing registration if all you do is write prescriptions and give samples. "Dispense" means a doctor 1) maintains a supply of prescription-only drugs, medications, or devices (excluding manufacturer's samples), 2) prescribes those for his or her patients, AND 3) sells them to the patient at his or her office, clinic, or practice location in Arizona (or bills a third-party payer for them). If your practice is a non-profit corporation registered with the AZ Corporation Commission and you do not sell the drugs, medications, or devices to your patients, the registration fee is waived.

- IF YOU ARE RENEWING BEFORE DEC 31ST, Please complete this form. This form must be postmarked before close of business on December 31st. There is no grace period for Dispensing Registration renewals. After December 31st, your Dispensing Physician Registration has expired and can no longer be renewed.
IF YOU ALLOWED YOUR PREVIOUS DISPENSING REGISTRATION TO EXPIRE, Please download and complete the Initial Dispensing Physician Registration form. To download the form, go to www.azdo.gov > For DOs > Dispensing Registration > Initial Dispensing Physician Registration Form.

INSTRUCTIONS:

- Please list below ALL locations where you will be dispensing prescription drugs, devices, and controlled substances.
For each location, place a check mark next to the descriptions of the prescription items which will be dispensed from that location.
Include a photocopy of your DEA certificate if you are requesting dispensing of prescription drugs at any location.

PLEASE NOTE: A separate DEA license number must be submitted for EACH location where controlled substances will be dispensed and must be kept current for that location during the registration period

PLEASE TYPE OR PRINT - IF PDF, FORM FIELDS CAN BE FILLED IN ELECTRONICALLY

Physician Name: _____, D.O. Date: _____ License # _____

Licensee DEA Certificate #: _____ Issue Date: _____ Expiration Date: _____

E-mail (required--your certificate(s) will be sent to you by email): _____

PRIMARY PRACTICE: LIST YOUR PRIMARY PRACTICE BELOW. LIST ANY ADDITIONAL LOCATIONS ON THE SECOND PAGE OF THIS FORM.

Name of Primary Practice: _____

Street Address: _____ Phone #: _____

City/State/Zip: _____ Fax #: _____

DEA # for This Location: _____ Issued Date: _____ Exp Date: _____

Schedule II Drugs [] Schedule IV Drugs [] Prescription Only Drugs []

Schedule III Drugs [] Schedule V Drugs [] Prescription Devices []

[] \$240.00 renewal fee for Dispensing Physician Registration for the 2012 calendar year, valid through December 31, 2012

[] My practice / dispensing is not for profit. (Attach copies of documentation filed with Arizona Corporation Commission which state your non-profit status in order to qualify for the fee waiver)

Make checks or money orders payable to 'Arizona Osteopathic Board'. For your convenience, we accept payments by Visa, MasterCard and American Express. If you wish to pay by credit card, please complete the attached Credit Card Payment Form.

I hereby attest that I am in compliance with the laws and rules regarding dispensing (A.R.S. §32-1871; AAC R4-22-107). I understand this registration expires on December 31st if not renewed.

Physician Signature _____ Date signed _____

Physician Name: _____ License No. _____

ADDITIONAL LOCATIONS
Copy page as needed for additional locations

Name of Practice: _____

Street Address: _____ Phone #: _____

City/State/Zip: _____ Fax #: _____

DEA # for This Location: _____ Issued Date: _____ Exp Date: _____

Schedule II Drugs Schedule IV Drugs Prescription Only Drugs

Schedule III Drugs Schedule V Drugs Prescription Devices

Name of Practice: _____

Street Address: _____ Phone #: _____

City/State/Zip: _____ Fax #: _____

DEA # for This Location: _____ Issued Date: _____ Exp Date: _____

Schedule II Drugs Schedule IV Drugs Prescription Only Drugs

Schedule III Drugs Schedule V Drugs Prescription Devices

Name of Practice: _____

Street Address: _____ Phone #: _____

City/State/Zip: _____ Fax #: _____

DEA # for This Location: _____ Issued Date: _____ Exp Date: _____

Schedule II Drugs Schedule IV Drugs Prescription Only Drugs

Schedule III Drugs Schedule V Drugs Prescription Devices

Name of Practice: _____

Street Address: _____ Phone #: _____

City/State/Zip: _____ Fax #: _____

DEA # for This Location: _____ Issued Date: _____ Exp Date: _____

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CREDIT CARD PAYMENT FORM
REGISTRATION TO DISPENSE MEDICATION IN ARIZONA

Physician Name: _____ Date: _____

Check or money order is payable to 'Arizona Osteopathic Board'. Discard/Recycle this form when paying by check.

Use this form if paying by Visa, MasterCard or American Express.

If faxing your application with this form, please do not mail the original as you may be charged twice.

Amount: \$ _____

Type of Card: Visa MasterCard American Express

Visa or MasterCard #: _____ - _____ - _____ - _____

OR

American Express #: _____ - _____ - _____

Expiration Date: _____ / _____ (MM/YY)

Name as Shown on Payment Card: _____

Billing Address: (Required)

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number of Card Holder: (Required) _____

Mailing Address (Required if different from billing address)

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number of Card Holder: (Required) _____

Signature of Cardholder: _____ Date: _____

Note: *The Board shreds this form after payment has been authorized by your credit card company*