



ARIZONA BOARD OF OSTEOPATHIC EXAMINERS
 9535 E. Doubletree Ranch Road | Scottsdale, AZ 85258
 PH: 480-657-7703 | FX: 480-657-7715
 questions@azdo.gov | www.azdo.gov

DISPENSING PHYSICIAN INITIAL REGISTRATION & ANNUAL RENEWAL FORM

If you had a Registration to Dispense 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.

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

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

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

Check One: Initial Registration (see prorated fee schedule) Renewal Registration (\$240.00)

REQUIRED:

- 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

PRIMARY PRACTICE LOCATION:

DEA # FOR THIS LOCATION (REQUIRED): _____

Name of Primary Practice:				DEA# Issue Date:		DEA# Expiration Date:	
Street Address:				City/State/Zip:			
Phone #:				Fax #		E-Mail:	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

*****List any additional locations on the second page of this form and place a check mark here: *****

REGISTRATION FEE OR DOCUMENTATION OF NON-PROFIT STATUS - Please check one:

1. Completed payment form below to pay \$240.00 (Renewal) or \$_____ (prorated fee – see chart at bottom of 1 st page) for this registration, valid until December 31 of 2010	<input type="checkbox"/>	2. Attached copies of documentation filed with Arizona Corporation Commission showing my practice / dispensing is not for profit; therefore the registration fee is waived.	<input type="checkbox"/>
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I hereby attest that I am in compliance with the rules on dispensing (AAC R4-22-107). I understand this registration must be renewed by Dec 31, 2010.

Physician Signature _____ Date signed _____

Make checks or money orders payable to Arizona Board of Osteopathic Examiners. 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.

PRORATED REGISTRATION FEE (A.R.S. §32-1826(A)(11))			
January	\$240.00	July	\$120.00
February	\$220.00	August	\$100.00
March	\$200.00	September	\$ 80.00
April	\$180.00	October (registration thru Dec 2011)	\$240.00
May	\$160.00	November (registration thru Dec 2011)	\$240.00
June	\$140.00	December (registration thru Dec 2011)	\$240.00

Physician's Name: _____ License No. _____

ADDITIONAL LOCATIONS – Copy page as needed for additional locations

ADDITIONAL PRACTICE LOCATION: _____ **DEA # FOR THIS LOCATION:** _____

Name of Practice:				DEA# Issue Date:		DEA# Expiration Date:	
Street Address:				City/State/Zip:			
Phone #:				Fax #:		E-Mail:	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

ADDITIONAL PRACTICE LOCATION: _____ **DEA # FOR THIS LOCATION:** _____

Name of Practice:				DEA# Issue Date:		DEA# Expiration Date:	
Street Address:				City/State/Zip:			
Phone #:				Fax #:		E-Mail:	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

ADDITIONAL PRACTICE LOCATION: _____ **DEA # FOR THIS LOCATION:** _____

Name of Practice:				DEA# Issue Date:		DEA# Expiration Date:	
Street Address:				City/State/Zip:			
Phone #:				Fax #:		E-Mail:	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

ADDITIONAL PRACTICE LOCATION: _____ **DEA # FOR THIS LOCATION:** _____

Name of Practice:				DEA# Issue Date:		DEA# Expiration Date:	
Street Address:				City/State/Zip:			
Phone #:				Fax #:		E-Mail:	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

ADDITIONAL PRACTICE LOCATION: _____ **DEA # FOR THIS LOCATION:** _____

Name of Practice:				DEA# Issue Date:		DEA# Expiration Date:	
Street Address:				City/State/Zip:			
Phone #:				Fax #:		E-Mail:	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			



ARIZONA BOARD OF OSTEOPATHIC EXAMINERS IN MEDICINE & SURGERY

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**PAYMENT CARD AUTHORIZATION
INITIAL OR RENEWAL REGISTRATION TO DISPENSE MEDICATION IN ARIZONA**

Name of Physician _____ Date _____

**Please complete and return this form and your application if paying by credit card.
This form and your application may be faxed to: 480-657-7715
If faxing this form, please do not mail the original as you may be charged twice.**

Due to the cost of processing credit cards, we do not accept credit card payments under \$25.00.
If the service you are requesting costs less than \$25, please send a check or money order with your written request or order form.

Amount: \$ _____ + \$8.00* = \$ _____
Total

***An \$8.00 processing fee is required for ALL credit card transactions**

Type of Card: Visa MasterCard American Express

Visa or MasterCard #: - - -

American Express #: - -

Expiration Date: _____ / (Month Name/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