NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane – Reno, NV 89509 – (775) 850-1440

NARCOTIC TREATMENT PROGRAM

CONTROLLED SUBSTANCE APPLICATION

Registration Fee: $80.00 (non-refundable money order or cashier's check only)

Name of Legal Entity: _____

Business Name: _____

Nevada Address: _____ Suite # _____

PO Box _____ Email address: _____

City: _____ State: NV Zip: _____

Nevada Telephone: _____ Fax: _____

Name of Administrator: _____

Medical Director: _____ License #: _____

1) Has the firm or any owner(s), shareholder(s) with any interest, officer(s) or director(s) thereof, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☐
2) Has the firm or any owner(s), shareholder(s) with any interest, officer(s) or director(s) thereof, ever been denied a license, permit or certificate of registration? Yes ☐ No ☐
3) Has the firm or any owner(s), shareholder(s) with any interest, officer(s) or director(s) thereof, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☐
4) Has the firm or any owner(s), shareholder(s) with any interest, officer(s) or director(s) thereof, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☐
5) Has the firm or any owner(s), shareholder(s) with any interest, officer(s) or director(s) thereof, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes ☐ No ☐

If you marked **YES** to any of the numbered questions (**1-5**) above, include the following information & **provide documentation**:

Board Administrative Action:	State	Date:	Case #:
		/ /	

Criminal Action:	State	Date:	Case #:	County	Court

I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct.

_____ _____

Medical Director's Original Signature, no copies or stamps accepted. Date

_____ _____

Administrator's Original Signature, no copies or stamps accepted. Date

Board Use Only Received: _____ Amount: _____ Entity# _____