

NEVADA STATE BOARD OF PHARMACY
 985 Damonte Ranch Pkwy Ste 206 – Reno, NV 89521
NARCOTIC TREATMENT PROGRAM
CONTROLLED SUBSTANCE APPLICATION Registration Fee: \$200.00
 (Non-refundable check or credit card. Credit Cards are charged a 5% processing fee)

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# _____



NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, Nevada 89521

(775) 850-1440 • 1-800-364-2081 • FAX (775) 850-1444

• Web Page: bop.nv.gov

Applicant Name: _____

Payment: Pay application fee by providing your credit or debit card information below, or by submitting a check made payable to **Nevada State Board of Pharmacy**.

Credit Cards are charged a 5% processing fee

Credit Type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> American Express		Credit Card #: _____	
Expiration Date: __ __ / __ __ (MM/YY)		CVV (3 digits on back of card): _____	License Amount: \$ _____
Name on Card: _____			
Billing Address: _____ _____ _____			