



State Of Arizona Board of Podiatry Examiners  
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Janice K. Brewer  
Governor

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Executive Director

## INITIAL REGISTRATION TO DISPENSE DRUGS AND DEVICES

If a disabled person needs this form in an alternative format, please contact the Board office at VOICE (602) 542-3095, VOICE RELAY (800) 842-4681. TDY (800) 367-8939.

**THIS REGISTRATION FORM SHALL BE SUBMITTED WITH AN INITIAL REGISTRATION FEE OF \$200.00 AND A COPY OF YOUR CURRENT DEA CERIFICATE FOR EACH LOCATION WHERE YOU WILL BE DISPENSING.**

Make Check Payable To: Arizona Board of Podiatry Examiners. (All returned checks will result in a NSF fee of \$25.00 and your registration will be void).

1. Physician's Full Name: _____	License No. _____
2. Mailing Address: Office Name (if any): _____ Street Address: _____ City: _____ State: _____ Zip Code: _____ Telephone: (____) _____ Fax: (____) _____	
3. Are you registered by the United States Department of Justice (DEA) to dispense controlled substances under the federal provisions of 21 U.S.C. 801, <i>et seq.</i> ? <b>YES</b> ____ <b>NO</b> ____	
List your DEA registration number: _____ Expiration date: _____	
A. List the types of controlled substances, prescription-only drugs, and prescription-only devices, you dispense or intend to dispense: _____ _____	
B. List the location(s) where you dispense or intend to dispense: _____ _____ _____	
4. Has any complaint or any action been taken against you by any court or any federal or state agency for the dispensing of any device or any drug? <b>YES</b> ____ <b>NO</b> ____	
If <b>YES</b> , explain on a separate sheet of paper and attach to this registration form the following: a. List the name and address of the court, the federal or state agency that the complaint was filed with; and, b. The action that was taken by the court, the federal or state agency.	
<b>I understand that an annual registration is required prior to dispensing controlled substances, prescription-only drugs, and prescription-only devices. I affirm that the information contained in this application is true and correct to the best of my knowledge and that any false statement herein could result in the suspension, revocation or other disciplinary action against my license.</b>	
Date: _____ Physician Signature: _____	