



Arizona Board of Osteopathic Examiners In Medicine and Surgery

1740 W. Adams Street, Suite 2410, Phoenix, Arizona 85007

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

Dispensing Registration Instructions

Arizona 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 registered with the IRS as a non-profit company and you do not sell the drugs, medications, or devices to your patients, the registration fee is waived.

How to Register to Dispense

- On the accompanying form, provide your name, license number, DEA information and primary dispensing location on the first page of the application.
- Copy page 3 as needed and list 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. This information will be listed on your dispensing registration certificate.
- If you are dispensing controlled substances (scheduled drugs) you must include a photocopy of your DEA certificate for each location at which you are registering to dispense controlled substances. The DEA certificate must show the same registered location(s) you are listing on this form.
- If you are registered as a non-profit company with the IRS, attach documentation of your organization’s current 501(c)(3) status in order to have the registration fee waived.
- You may submit the Initial Registration to Dispense Medication Form, documentation and fee by fax, email or regular mail. Please allow up to 30 days for processing.
- If your dispensing registration is approved, your dispensing certificate will be sent to the email address provided on the first page of the form.



Arizona Board of Osteopathic Examiners In Medicine and Surgery

1740 W. Adams Street, Suite 2410, Phoenix, Arizona 85007

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

INITIAL REGISTRATION TO DISPENSE MEDICATION FORM

Use this form if you are applying for a Dispensing Physician Registration for the first time, or if you allowed your Dispensing Physician Registration to expire.

In accordance with A.R.S. § 41-1030 The Board is required to notify you of the following:

- B. An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition.
- D. This section may be enforced in a private civil action and relief may be awarded against the state. The court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the state for a violation of this section.
- E. A state employee may not intentionally or knowingly violate this section. A violation of this section is cause for disciplinary action or dismissal pursuant to the Agency's adopted personnel policy.
- F. This section does not abrogate the immunity provided by section 12-820.01 or 12-820.02.

PLEASE NOTE: A *separate* DEA certificate must be submitted for *EACH* location where scheduled drugs 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 2 Drugs Schedule 4 Drugs Prescription Only Drugs

Schedule 3 Drugs Schedule 5 Drugs Prescription Devices

\$_____ prorated fee for Initial Registration to Dispense for the current calendar year, valid until December 31 of the current year (Please use the fee table at the bottom of the form to determine your fee requirements)

My practice / dispensing is not for profit. (Include documentation of your organization's current 501(c)(3) status in order to qualify for the fee waiver)

INITIAL 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 next year)	\$240.00
May	\$160.00	November (registration thru Dec next year)	\$240.00
June	\$140.00	December (registration thru Dec next year)	\$240.00

I hereby attest that I am in compliance with the laws and rules regarding dispensing. I understand this registration expires on December 31st if not renewed.

Physician Signature _____ Date signed _____

Physician's 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 2 Drugs Schedule 4 Drugs Prescription Only Drugs

Schedule 3 Drugs Schedule 5 Drugs Prescription Devices

Name of Practice: _____

Street Address: _____ Phone #: _____

City/State/Zip: _____ Fax #: _____

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

Schedule 2 Drugs Schedule 4 Drugs Prescription Only Drugs

Schedule 3 Drugs Schedule 5 Drugs Prescription Devices

Name of Practice: _____

Street Address: _____ Phone #: _____

City/State/Zip: _____ Fax #: _____

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

Schedule 2 Drugs Schedule 4 Drugs Prescription Only Drugs

Schedule 3 Drugs Schedule 5 Drugs Prescription Devices

Name of Practice: _____

Street Address: _____ Phone #: _____

City/State/Zip: _____ Fax #: _____

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

Schedule 2 Drugs Schedule 4 Drugs Prescription Only Drugs

Schedule 3 Drugs Schedule 5 Drugs Prescription Devices



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