



## Dispensing Physician Registration Renewal Application Instructions

If you have a Dispensing Registration 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.

### ARE YOU USING THE CORRECT FORM?

Use this form if you have an Active 2016 Dispensing Registration and intend to renew your registration for calendar year 2017 *on or before* December 31, 2016.

- This form must be postmarked (or faxed) before close of business on December 31<sup>st</sup>.
- **There is no grace period** for Dispensing Physician Registration renewals. This means after December 31<sup>st</sup> your Dispensing Registration will expire and can no longer be renewed.
- **IF YOUR REGISTRATION HAS EXPIRED**, or you have not registered to dispense before, please download and complete the **Initial Dispensing Physician Registration form**. To download the form, go to [www.azdo.gov](http://www.azdo.gov) > For DOs > Dispensing Registration > Dispensing Initial Registration Form.

### Do You Need a Dispensing Registration?

**You do not need a dispensing registration if all you do is write prescriptions and give samples.** In accordance with Arizona statutes (A.R.S. § 32-1871) you are required to 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 Arizona Pharmacy Board.

### How to Renew your Dispensing Registration

- Please review your compliance with the requirements for dispensing found in A.R.S. § 32-1871 and A.A.C. Title 4, Chapter 22, Article 3. These Statutes and Rules are available on our website.
- 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 your name and the same registered location(s) you are listing on this form. This is required even if you submitted it last year.
- If you are registered as a non-profit entity with the IRS, attach documentation of your organization's current 501(c)(3) status in order to qualify for the fee waiver.
- You may submit the Dispensing Physician Registration Renewal Application, documentation and fee by fax, email, mail or delivery service. Please allow up to 30 days for processing.
- If your dispensing registration renewal is approved, your dispensing certificate will be sent to the email address provided on the first page of the form.



## DISPENSING PHYSICIAN REGISTRATION ANNUAL RENEWAL FORM

**If you have a Dispensing Registration 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 at www.azdo.gov.**

**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 registration must be held for **EACH** location where scheduled drugs will be dispensed. A copy of your DEA registration for each location must be provided with your renewal application and kept current during the registration period.

**PLEASE TYPE OR PRINT. IF PDF DOCUMENT, FORM FIELDS CAN BE COMPLETED IN ADOBE ACROBAT**

Physician Name: \_\_\_\_\_, D.O. Date: \_\_\_\_\_ License # \_\_\_\_\_

Licensee DEA Certificate #: \_\_\_\_\_ Issue Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Email (**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 Registration # for This Location: \_\_\_\_\_ Issued Date: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Schedule II Drugs  Schedule IV Drugs  Prescription Only Drugs

Schedule III Drugs  Schedule V Drugs  Prescription Devices

**\$240.00 renewal fee** for Dispensing Physician Registration for the 2017 calendar year, valid through December 31, 2017.

My practice/dispensing is not for profit. I request a fee waiver for Dispensing Physician Registration for the 2017 calendar year. (Attach documentation of your organization's current 501(c)(3) status in order to qualify for the fee waiver.)

**Make checks or money orders payable to 'Arizona Osteopathic Board'. 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.**

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

Physician Signature \_\_\_\_\_ Date signed \_\_\_\_\_

Physician 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 II Drugs  Schedule IV Drugs  Prescription Only Drugs

Schedule III Drugs  Schedule V Drugs  Prescription Devices

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Name of Practice: \_\_\_\_\_

Street Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Fax #: \_\_\_\_\_

DEA # for This Location: \_\_\_\_\_ Issued Date: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Schedule II Drugs  Schedule IV Drugs  Prescription Only Drugs

Schedule III Drugs  Schedule V Drugs  Prescription Devices

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Name of Practice: \_\_\_\_\_

Street Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Fax #: \_\_\_\_\_

DEA # for This Location: \_\_\_\_\_ Issued Date: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Schedule II Drugs  Schedule IV Drugs  Prescription Only Drugs

Schedule III Drugs  Schedule V Drugs  Prescription Devices

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Name of Practice: \_\_\_\_\_

Street Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Fax #: \_\_\_\_\_

DEA # for This Location: \_\_\_\_\_ Issued Date: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Schedule II Drugs  Schedule IV Drugs  Prescription Only Drugs

Schedule III Drugs  Schedule V Drugs  Prescription Devices



**CREDIT CARD PAYMENT FORM**

Name of Physician \_\_\_\_\_ Date \_\_\_\_\_  
 (if applicable)

Item/Service Requested: \_\_\_\_\_

This form and your order/application may be faxed to: 480-657-7715  
*If faxing 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 #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**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*