



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

APPLICATION FOR REGISTRATION

Noncontrolled Substances Report and Registration Act (Act 11-1990)

Type or print answers to all questions. Use "Not Applicable" where appropriate. Complete and return this application to:

Pennsylvania Department of Health, Drug, Device and Cosmetic Program, 132 Kline Plaza, Suite A, Harrisburg 17104,
(717) 783-1379 or Fax (717) 772-0232

An application must be filed for **EACH** noncontrolled substance manufacturing plant, distributor, and retail outlet operating within or distributing into the Commonwealth of Pennsylvania.

PLEASE CHECK BLOCKS WHICH APPLY

- Manufacturer of Noncontrolled Substance Products
- Distributor of Noncontrolled Substance Products
- Retailer of Noncontrolled Substance Products
- Other persons – Identify _____

Name(s) of List 1 Chemicals Distributed _____

1. Name of Firm _____ Telephone Number + Area Code _____

2. Address (Number, Street, City, County, Zip Code) DO NOT USE P.O. BOX NO.

3. Mailing Address if Different from Above

4. If Corporation, Name State in Which Firm is Incorporated _____ Date Incorporated _____

5. Name, Address (other than P.O. Box No.), Telephone Number & Occupation of all Owners of Firm Listed in Question #1
(Use additional paper if necessary)

6. If Branch or Subsidiary, List the Name, Mailing Address and Telephone Number of Main Office or Parent Firm

7. If Main Office or Parent Firm, List the Name(s), Address(es), and Telephone Number of Branch or Subsidiary Firm(s)
(Use additional paper if necessary)

Authorized Agent's Signature _____ Date _____

Authorized Agent's Name –Print or Type _____

Title (Owner, Partner, or Officer of Corporation) _____



Commonwealth of Pennsylvania
Department of Health
132 Kline Plaza, Suite A
Harrisburg, PA 17104

(717) 783-1379 FAX (717) 772-0232

NONCONTROLLED SUBSTANCE REPORTING FORM

(Circle Quarter) 1 -2 -3 -4 Year _____

Company Name _____

Address (do not use P.O. Box) _____

Area Code and Phone Number _____

Owner's Name _____

Address (do not use P.O. Box) _____

Area Code and Phone Number _____

Occupation _____

Attach additional sheets of paper if business has multiple owners. Also list names, addresses, and telephone numbers of all subsidiaries and field locations of operation of registered firm on additional sheets of paper.

Mail completed report forms to **BOTH** of the following agencies:

PA Dept. of Health
Drug, Device & Cosmetic Program
132 Kline Plaza, Suite A
Harrisburg, PA 17104
717-783-1379

Office of Attorney General
Drug Prosecution Section
16th Floor, Strawberry Square
Harrisburg, PA 17120
717-783-2600

H114.620 (01/01)
(Form may be reproduced)

SALES RECORDS

Purchaser' s Name _____

Address _____

(DO NOT USE P.O. BOX)

Agent' s Name (If Applicable) _____

Date of Birth _____

Social Security No. _____

On file –copy of (check Yes or No)

Drivers License # / with photo Yes No

Vehicle License # Yes No

Letter of Authorization of Purchase Yes No

Sale - Date _____ Time _____

Location _____

Item/quantity/price _____

Cash Check Money Order Other (please identify) _____

If check, money order or draft: indicate the name and address of financial institution, number on document, name and address of signer and date of issuance.)

Purchaser' s Name _____

Address _____

(DO NOT USE P.O. BOX)

Agent' s Name (If Applicable) _____

Date of Birth _____

Social Security No. _____

On file –copy of (check Yes or No)

Drivers License # / with photo Yes No

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