Capital Wholesale Drug Company
Controlled Substance Information Survey (CSIS)

Sales Rep Name:	
Customer Account Name:	
Customer DBA Name, if any:	
Customer Address:	
City/State/Zip	
Customer Phone:	
Customer Email:	
Customer Account Number:	

Reviewed by Capital Wholesale Drug Company

Accepted_____ Declined_____

_____ _____
(Signature) (Date)

New Customer go live date:

Existing customer since: (MM/YYYY)

Please FAX the completed Controlled Substance Information Survey and STATE and DEA LICENSES

Fax survey to 1-800-536-9686 Cincinnati or 614-297-8224 Columbus

The Controlled Substance Information Survey must be completed and faxed back before any controlled substances will be shipped.

To ensure compliance with requirements of individual state licensing boards and to ensure compliance with the requirements of the Code of Federal Regulations on the sale of Controlled Substances, Capital Wholesale Drug Company must perform due diligence on each customer where prescription drugs and/or controlled substances are purchased. We ask that you complete the below questionnaire, attach information where requested, and return the information. All information will be held in strict confidence.

Section I - State Governing Board and Licensing Information	
1. State of Licensure and type of license, e.g., pharmacy, practitioner, wholesaler, hospital/clinic, etc.	
2. Enter your state license number, state controlled substance registration number (if applicable), and expiration date(s). Do not forget to attach a copy of your current state license(s).	
3. For the pharmacist-in-charge, list the name, state license number, and expiration date. (Attach a copy of the current state license.)	
4. At any time in the last 5 years have you been inspected by a state governing board, the State Board of Pharmacy, or the State Medical Board? If yes, provide a separate sheet of paper stating the results of this inspection and corrective actions taken and attach any documentation.	
5. Are you or your pharmacist-in-charge currently under investigation by the Board of Pharmacy, Medical Board, any or state governing board? If yes, provide a synopsis of the investigation on a separate sheet of paper and attach any documentation.	
6. Have you, your company or business, or your pharmacist-in-charge ever had a license denied, revoked or suspended by any state governing board? If yes, attach a separate sheet of paper stating the reason(s) for any of these actions.	

Section II - General Compliance and Business Information	
1. Provide the name of the employee that is directly responsible for ensuring that prescription drugs and/or controlled substances are adequately safeguarded in accordance with state and federal regulations. This person is normally the Pharmacist-in-Charge, Medical Practitioner or Designated Representative.	
2. Provide the email address and telephone number of the employee listed above.	
3. Provide the name of the employee or purchasing agent that is responsible for the purchasing of prescription drugs and controlled substances. If these are two separate employees, enter the name of each employee along with the email address and telephone number for direct contact.	
4. Indicate the number of years you have been operating under the current state license(s) and DEA registration.	

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5. If your company has been in operating under your current state license(s) and DEA registration for less than 12 months, have you, your company, or your pharmacist-in-charge previously operated a pharmacy or licensed facility? If so, disclose the name of the facility, the address, and the previous state license number(s) and DEA registration number.	
6. Is your facility currently under investigation by the Board of Pharmacy, Medical Board, any or state governing board? If yes, provide a synopsis of the investigation on a separate sheet of paper and attach any documentation.	
7. Do you resell any prescription drugs or controlled substances to other wholesale distributors or pharmacies? If yes, you must attach a listing of these customers along with addresses and telephone numbers.	
8. Do you fill scripts for Pain Management Clinics or Pain Management Physicians? If yes, please list the names, addresses, state license numbers and DEA registration numbers.	
9. Are any of the Pain Management Clinics or Physicians currently under investigation by the Board of Pharmacy, Medical Board, any or state governing board? If yes, provide a synopsis of the investigation on a separate sheet of paper and attach any documentation.	
10. Do you fill prescriptions issued by practitioners from outside your normal service area or for patients who do not reside within your normal service area? If yes, provide details. Estimate the number of such controlled substance prescriptions received per month and the circumstances under which such controlled substance prescriptions are received and filled.	
11. Do you operate an Internet Site that offers the sale of pharmaceutical products (prescription drugs and/or controlled substances) to the general public? If Yes, indicate the website address and the number of years you have operated this website.	
12. If you operate a website that offers the sale of pharmaceutical products to the general public, you must attach a copy of your Verified Internet Pharmacy Practice Site (VIPPS) Accreditation or Verified Accredited Wholesale Distributor (VAWD) Accreditation.	

Section III - Controlled Substance Registration Information	
1. Enter your federal DEA Number and expiration date. Do not forget to attach a copy of current DEA registration	
2. List the business name and/or name of individual as it appears on your DEA controlled substance registration certificate	
3. List the License Type. For example: Retail Pharmacy, Practitioner, Distributor, Hospital/Clinic. (Disclose whether you have any modifications to your DEA registration, such as a DATA waiver for physicians)	
4. List the name of the person who signed the original application for the registration and/or the most recent renewal submitted to the DEA.	
5. List the name of the person(s) authorized to execute (sign) DEA Forms 222 on behalf of the registrant	
6. We reserve the right to ask for a Power of Attorney at any time another person executes a DEA Form 222 in the registrant's behalf.	
7. Does the pharmacy employ as an agent or employee who has access to controlled substances any person who has been convicted of a felony offense related to controlled substances or who, at any time, had an application for a DEA registration denied, had a DEA registration revoked, or voluntarily surrendered a DEA registration? If yes, has the appropriate waiver been obtained from DEA? Please attach copy of the waiver for any company employee or agent.	
8. Are you or the pharmacist-in-charge or any employee currently under investigation by the DEA? If yes, provide a synopsis of the investigation on a separate sheet of paper.	
9. Have you or the pharmacist-in-charge been investigated or inspected by the DEA in the last five years? If yes, provide a separate sheet of paper stating the results of the inspection or investigation and any corrective actions taken.	
10. Have you or your company or business ever had a DEA controlled substance registration denied, revoked, suspended, or subjected to a memorandum of agreement/understanding? If yes, provide details of this action on a separate sheet of paper and attach a copy of documentation..	
11. List the average number of non-controlled substance prescriptions filled per day.	
12. List the average number of controlled substance prescriptions filled per day.	
13. List the method of payment by patients for non-controlled substance prescriptions (total should equal 100%).	Cash/Credit Card/Check: _____% Insurance: _____% Medicare/Medicaid: _____% Workers' Comp: _____%
14. List the method of payment by patients for controlled substance prescriptions (total should equal 100%).	Cash/Credit Card/Check: _____% Insurance: _____% Medicare/Medicaid: _____% Workers' Comp: _____%
15. Do you purchase controlled substances from distributors other than Capital Wholesale? If yes, please list in area provided.	YES ☐ NO ☐
16. If yes, list the wholesalers you have used in the past 12 months and the percentage of controlled and non-controlled substances purchased from each. Include Capital Wholesale. (Total should equal 100%).	
17. For controlled substance sales, you MUST indicate below all types of customers that purchase controlled substances from your business. Please circle yes or no and provide percentages. (Total should equal 100%).	

Types of Customers Served (Yes or No)			Percent of Customer base	Comments
Patients	Yes ☐	No ☐		
Hospice Patients	Yes ☐	No ☐		
Pain clinic Patients	Yes ☐	No ☐		
Diet Clinics	Yes ☐	No ☐		
Emergency Clinics	Yes ☐	No ☐		
Government Agencies	Yes ☐	No ☐		
Hospice Pharmacies	Yes ☐	No ☐		
Hospitals	Yes ☐	No ☐		
Internet Pharmacies	Yes ☐	No ☐		
Mail Order	Yes ☐	No ☐		
Nursing Homes/Assisted Living	Yes ☐	No ☐		
Pain Clinics	Yes ☐	No ☐		
Pharmacies	Yes ☐	No ☐		
Physicians	Yes ☐	No ☐		
Wholesale Distributors	Yes ☐	No ☐		
OTHER --Please indicate	Yes ☐	No ☐		

Please attach a copy of your policy and procedure plan for handling and dispensing controlled substances.

We thank you for furnishing the information above and for attaching the supporting documentation as requested.

If you have questions, please contact James Bergados ph. (614) 297-8225 fax (614) 297-8224

Your signature is required below.

I certify under penalty of perjury that the forgoing information is true and correct. I also agree to contact Capital Wholesale Drug Company if there is any change in the regulatory status of this business, such as a change in licensure or ownership.

_____ _____

(Signature of person identified in section II, question 1) **(Date)**

_____

(Print name)

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