

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE - PUBLIC HEALTH SERVICES
DIVISION OF DRUG CONTROL REGISTRATION FOR CONTROLLED DANGEROUS SUBSTANCES (CDS)



4201 Patterson Avenue – 5th Fl., Baltimore, Maryland 21215

DDC Website: <http://dlnh.maryland.gov/laboratories/drugcont> ■ DDC Email: MDDC@Maryland.Gov

Main Office: (410) 764-2890 ■ Fax: (410) 358-1793 ■ Customer Service: (410) 764-5910, (410) 764-7980, (410) 764-4159

PRACTITIONER APPLICATION	3-YEAR CDS REGISTRATION/CERTIFICATION	CDS #: M90770
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RECEIVED

APR 15 2016

CSNJ

FOR OFFICE USE ONLY: APPLICATION AUDIT CONTROL SECTION

Processor Initials: _____

Date: ____/____/____

Note: _____

Do Not Write In This Section..

SEE INSTRUCTIONS ATTACHED. TYPE ENTRIES IN SECTIONS 1, 2 AND 3 BELOW. SIGN, DATE APPLICATION AND INCLUDE PAYMENT. INCOMPLETE APPLICATIONS WILL BE RETURNED AND DELAYS CDS ISSUANCE. AS NOTED BELOW, UPDATED DELEGATION AGREEMENT AND RESEARCHER QUESTIONNAIRE REQUIRED, AS WELL AS OTHER DOCUMENTATION AS LISTED IN THE ATTACHED INSTRUCTIONS. EMAIL ADDRESS REQUIRED FOR RENEWAL NOTIFICATION.* KEEP COPY OF APPLICATION FOR YOUR RECORDS.

SECTION 1: APPLICATION CLASSIFICATION, TYPE, PAYMENT AND FEE EXEMPT DETAILS

A. CLASSIFICATION-Select Profession: MD DDS DMD DO DPM DVM VMD CRNP CNM EMS/Med.Dir.
 PA – Insert name of Physician or attach Updated Delegation Agreement (_____ Required)
 Researcher Schedule I (Prior DEA approval) Researcher Schedules II, III, IV, V (Researchers must submit a Researcher Questionnaire.) See instructions for other documentations required. Lawful registration requires separate application for each Profession.

B. FEE PAYMENT DETAILS	FOR OFFICE USE ONLY	C. FEE EXEMPT DETAILS FOR GOVERNMENT AGENCIES
(Fee Payable to DHMH-Drug Control)	App. Receive Date: <u>4/15/16</u>	CHECK TYPE: <input type="checkbox"/> State <input type="checkbox"/> Local (Agency Unit Code: _____)
TYPE	Deposit Date: <u>4/26/16</u>	Agency/Institution name
Renewal**	Check/Mo #: <u>1375</u>	Division/Department
New	Processor Initials: <u>CSAD</u>	Agency/Institution business address
Address Change Only	Do not write in this section.	Contact Telephone #
Name Change Only		Print Certifier name
Duplicate CDS Permit		Title of Certifier
Discontinuation (List Reason):		Date: ____/____/____
(Fees are Non-Refundable.)		(Signature of Certifier)

**No fee for name/address change at time of renewal.

SECTION 2: APPLICANT DETAILS	SECTION 3: PROFESSIONAL LICENSE DETAILS
A. Name (print)	A. Professional License # _____
(First) <u>Jennifer</u>	Expiration Date: <u>9/30/17</u>
(Middle) <u>Acton</u>	B. Federal DEA #: _____
(Last) <u>Robinson</u>	Expiration Date: <u>4/30/19</u>
B. Business Name	C. Social Security or Tax #: _____
<u>JHBMC - Dept. of OB/Gyn</u>	D. Is your professional license currently or has it ever been denied, suspended, restricted, revoked, reprimanded or placed on probation? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Business Street Address	E. Is your license currently under any restriction or on probation for reasons related to CDS by a Health Occupations Board, a State or federal agency? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<u>4940 Eastern Ave., A Bldg, Rm 121</u>	F. Has there been adverse action taken against your Professional license in another state/country? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
City/County/State/Zip	G. Have you ever been convicted of a felony violation or a violation pertaining to your profession? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<u>Baltimore MD 21224</u>	If yes is the answer to any of the above questions, submit a detailed explanation and copies of pertinent/supporting documentation.
C. Mailing Address	
City/State/Zip	
D. Home Address	
City/State/Zip	
E. Telephone Nos.	
Business: <u>410-550-0337</u>	
Fax No.: <u>410-550-0196</u>	
Alternate or Cell: _____	
F. Email* (Required)	
SIGNATURE: _____	DATE: <u>4/8/16</u>
	Your signature attests to the fact that the information provided is accurate.

REGISTRATION / CERTIFICATION

USE FORM BELOW FOR NAME AND/OR ADDRESS CHANGES.
 DRUG CONTROL MUST BE NOTIFIED OF THESE CHANGES IMMEDIATELY

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 DIVISION OF DRUG CONTROL
 4201 PATTERSON AVE. BALTIMORE, MD 21215
 Telephone number: 410-764-2890

**DEPARTMENT OF HEALTH AND MENTAL
 HYGIENE
 DIVISION OF DRUG CONTROL**

JENNIFER A ROBINSON MD

JENNIFER A ROBINSON MD
JHBMC - OB/GYN-A BLDG
 4940 EASTERN AVE - RM 121
BALTIMORE MD 21224

CDS REG. NO.	EXPIRATION DATE
M70770	04/30/2019

[Signature] Chief, Division of Drug Control *[Signature]* Secretary of Health and Mental Hygiene



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 DIVISION OF DRUG CONTROL
 4201 PATTERSON AVE. BALTIMORE, MD 21215
 Telephone number: 410-764-2890

This registration is granted pursuant to title 5 of the Criminal Law Article of the Annotated Code of Maryland, as amended from time to time and is subject to all applicable statutes, rules and regulations regarding Controlled Dangerous Substances.

JENNIFER A ROBINSON MD
JHBMC - OB/GYN-A BLDG
 4940 EASTERN AVE - RM 121
BALTIMORE MD 21224

CDS REG. NO.	EXPIRATION DATE
M70770	04/30/2019

[Signature] Van T. Mitchell Secretary of Health and Mental Hygiene *[Signature]* Audrey P. Clark Chief, Division of Drug Control

(Non Transferable)

POST IN A CONSPICUOUS PLACE

ADDRESS AND/OR NAME CHANGE FEE \$50-PAYBLE TO DHMH-DRUG CONTROL	ADDRESS AND/OR NAME CHANGE, PLEASE PRINT	
	CDS Reg. Cert. No.	
Check box: <input type="checkbox"/> Business Address Change <input type="checkbox"/> Name Change Request: Attach Court Documents <input type="checkbox"/> Mailing Address Change - No Fee (other than the address on the CDS permit)	Last Name and Generational Indicator (JR., III, etc.)	
	First Name and Middle Name/Initial	
	Street Address	
	City	State Abbreviated
	Zip Code	Telephone Number