

# The Commonwealth of Massachusetts

DEPARTMENT OF PUBLIC HEALTH, DIVISION OF FOOD AND DRUGS  
335 SOUTH STREET, JAMAICA PLAIN, MA. 02130



## REGISTRATION IN ACCORDANCE WITH MASSACHUSETTS GENERAL LAWS

Chapter 94C

NUMBER

ISSUED

EXPIRES

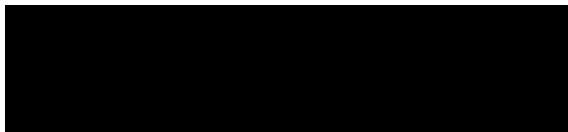
TYPE

MA0388567 R  
ISSUED TO

03/15/98

CONTROLLED SUBSTANCES PRACTITIONER  
SCHEDULES II, III, IV, V

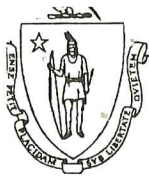
AUGUST, BETSY, MD



COMMISSIONER OF PUBLIC HEALTH


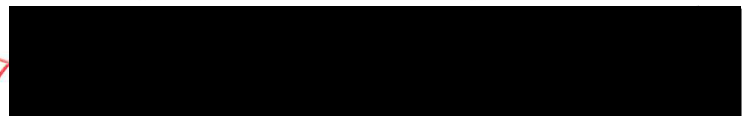
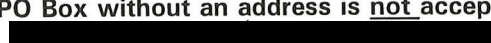


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RECALL



Commonwealth of Massachusetts Department of Public Health  
Registration Application Form  
Authorized under Massachusetts General Law Chapter 94C, Controlled Substances Act

MAR 15 1995

<p>DEA Number <b>BA1404956</b></p>  <p>BETSY S AUGUST, MD</p> <p><input type="checkbox"/> Please check box if not registering and state reason (retired, out of state, declined, deceased, etc.)</p>		<p>To receive a MA controlled substances registration:</p> <p>A. Fill out form completely. Type or print clearly, answering all required questions</p> <p>B. Enclose \$50 check or money order payable to Commonwealth of Massachusetts</p> <p>C. Enclose copy of <u>current Massachusetts Board of Reg. Medical/Dental/Podiatry/Veterinary License</u></p> <p>D. Mail to:</p> <p>DEPARTMENT OF PUBLIC HEALTH Division of Food and Drugs 305 South Street Jamaica Plain, MA 02130</p>
<p>1. If enclosed name and/or MA business address is incorrect, make corrections in this space</p> <p></p> <p>PO Box without an address is <u>not</u> acceptable</p> <p></p>		
<p>2. Registration Classification (Please circle) <u>MD</u> DMD DDS DVM VMD DO DPM</p>		
<p>3. MA Board of Reg. in [Medicine/Dentistry/Podiatry/Veterinary Medicine] No. <u>59447</u></p> <p>Write Board of Registration # on line and <b>ALSO ENCLOSE COPY OF CURRENT LICENSE</b></p>		
<p>4. Business Telephone # (optional) </p>		
<p>5. Social Security or Federal Identification # (optional) </p>		
<p>6. Drug Schedule Requested (Check all applicable) II <input checked="" type="checkbox"/> III <input checked="" type="checkbox"/> IV <input checked="" type="checkbox"/> V <input checked="" type="checkbox"/> via <input type="checkbox"/></p> <p>Schedule VI drugs are all prescription drugs NOT listed in Federal Schedules II through V.</p>		
<p>7. Have you been convicted of any violation of State or Federal law relation to the manufacturing, distribution or dispensing of controlled substances? YES* <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		
<p>8. Has any previous registration held by you under any name or corporate legal entity been surrendered, suspended or denied or is it pending such action? YES* <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		
<p>*If Yes to questions 7 or 8, , a letter MUST be attached setting forth circumstances of such action(s)</p>		

I hereby certify that the information on this application is true to the best of my knowledge, and that I will comply with the laws of the Commonwealth of Massachusetts and all applicable rules and regulations promulgated by the Department of Public Health. I also certify, pursuant to MGL c62C, s.49A, that I have to the best of my knowledge and belief filed all state tax returns and paid all state taxes required under law.

Signed under the pains and penalties of perjury.

Signature of applicant (no initials) Betsy Augustus Date 3/6/95

windows/recall/rec11app.doc 01/27/95

MAR - 7 1995

OK BT  
3/15/95

COMMONWEALTH OF MASSACHUSETTS  
BOARD OF REGISTRATION IN MEDICINE  
William F. Weld, Governor

ISSUES THIS LICENSE TO

BETSY S AUGUST M.D.

AS A REGISTERED PHYSICIAN

59447

05/19/95

1056882

REGISTRATION NO.	EXPIRATION DATE	SERIAL NO.
59447	05/19/95	1056882

IMPORTANT

If this license is lost or destroyed, notify the Board of Registration in Medicine at 10 West St., Boston, MA 02111, (617) 727-3086. If your name or address is changed, you are required to notify the Board immediately in writing. Always refer to your registration number.

Registration is subject to the provisions of the General Laws and the Board's regulations. Keep this license on your person as required by law. Provide your signature where noted on the license.

Betsy August M.D.  
(Signature)