

The Commonwealth of Massachusetts

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



REGISTRATION

In Accordance with Massachusetts General Laws Chapter 94C

NUMBER	ISSUED	TYPE
MS0736097A	10/03/08	CONTROLLED SUBSTANCES PRACTITIONER
		SCHEDULES
		II,III,IV,V,VI

ISSUED TO

SPURRELL, TIMOTHY P MD
redacted

COMMISSIONER OF PUBLIC HEALTH

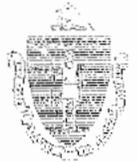
442549

FILE COPY

NEW REGISTRANT

The Commonwealth of Massachusetts

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



REGISTRATION

In Accordance with Massachusetts General Laws Chapter 94C

NUMBER	ISSUED	TYPE
MS0736097A	10/03/08	CONTROLLED SUBSTANCES PRACTITIONER
		SCHEDULES
		II,III,IV,V,VI

ISSUED TO SPURRELL, TIMOTHY P MD
redacted

redacted

COMMISSIONER OF PUBLIC HEALTH

442549

VERIFICATION COPY

NEW REGISTRANT



Commonwealth of Massachusetts, Department of Public Health, Division of Food and Drugs
305 South Street, Jamaica Plain, MA 02130
Telephone 617 983-6700 Fax 617 524-8062

Application for Massachusetts Controlled Substances Registration for Practitioners
In Accordance with the Controlled Substances Act, M.G.L. Chapter 94C

Please be sure to:

- Complete the application form.
- Enclose check or money order for \$150.00 made payable to "Commonwealth of Massachusetts".
- No fee is charged if submitting this form only for *Amended Information*.
- Enclose a photocopy of your current Board of Registration license (wallet-size).
- Sign and date the form at the bottom.
- Mail to the address above.

Incomplete applications will be returned and will cause a delay in receiving your MCSR. Where photocopied licenses are to be submitted along with your application, do not send originals. They will not be returned. For further information visit our Web site at <http://www.mass.gov/dph/dcp>.

Application Type: (Please select one) New Amended Information

In the boxes below enter the requested information:

1) Degree: (Select one)
 MD DMD DDS DVM VMD DO DPM

2) Massachusetts Board of Registration License No.: 236470

3) DEA Controlled Substance Registration No. (If possessed): B56895695

4) Name:
 First: Timothy Middle: Patrick Last: Spurrell
 Suffix: (e.g. Jr., Sr., II, III)

5) Business Address: Applications that include a P.O. Box number without a street address or rural addresses require a letter of explanation.
 redacted
 Facility Name and Department (if applicable):
 Street:
 City: redacted ZIP: redacted

6) Business Telephone No.: redacted
 area code

7) Social Security No.: (Required by M.G.L. c. 30A, s. 13A) redacted

8) Drug Schedules requested: Select all that apply: II III IV V VI
 Schedule VI includes all prescription drugs not in Schedules II - V. Only Schedules that are checked can be authorized.

9) Have you ever been convicted of any violation of State or Federal law relating to the manufacture, possession, distribution or dispensing of controlled substances?
 Yes * No

10) Has any previous professional license or registration held by you under any name or corporate name or legal entity been surrendered, revoked, suspended or denied or is such action pending?
 Yes * No

* If you answered "Yes" to Question No. 9 or No. 10, a letter must be attached setting forth circumstances of such action(s).

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, in accordance with M.G.L. c. 62C, 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) [Signature] Date 9/24/08

Practitioner Application

Rev. 20070307-01

OCT 03 2008

COMMONWEALTH OF MASSACHUSETTS

Board of Registration in Medicine



Active License



Timothy P Spurrell
redacted redacted

Lic. # 236470
Expires: 02/16/2009

The Commonwealth of Massachusetts

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



REGISTRATION

In Accordance with Massachusetts General Laws Chapter 94C

NUMBER ISSUED
MS0736097A 09/13/11

TYPE
CONTROLLED SUBSTANCES PRACTITIONER
SCHEDULES
II,III,IV,V,VI

ISSUED TO

SPURRELL, TIMOTHY P MD
redacted

COMMISSIONER OF PUBLIC HEALTH

FILE COPY

RECALL

537516



The Commonwealth of Massachusetts

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

REGISTRATION

In Accordance with Massachusetts General Laws Chapter 94C



NUMBER ISSUED
MS0736097A 09/13/11

TYPE
CONTROLLED SUBSTANCES PRACTITIONER
SCHEDULES
II,III,IV,V,VI

ISSUED TO SPURRELL, TIMOTHY P MD
redacted

COMMISSIONER OF PUBLIC HEALTH

VERIFICATION COPY

RECALL

537516





Commonwealth of Massachusetts, Department of Public Health, Division of Food and Drugs
305 South Street, Jamaica Plain, MA 02130-3515
Telephone (617) 983-6700 Fax (617) 524-8062

Application for Massachusetts Controlled Substances Registration for Practitioners

Recall application notice for all practitioner Massachusetts Controlled Substances Registrations issued in 10/03/2008 (in accordance with the Controlled Substances Act, M.G.L. Chapter 94C).



2H90UFP1Z

TIMOTHY P SPURRELL, MD

redacted

Please be sure to:

- Complete the application form;
- Enclose check or money order for \$150.00 made payable to "Commonwealth of Massachusetts";
- Enclose a photocopy of your current Board of Registration license (wallet-size);
- Sign and date the form at the bottom;
- Mail to the address above.

If not registering, please check the appropriate box and return the form to the address above.

- Do not prescribe, possess, dispense or administer controlled substances (i.e. prescription drugs) in Massachusetts
- Retired Deceased

Cross out any information needing changes in items No. 1 through No. 8 and enter corrections in the column to the right

For items No. 1 through No. 8 enter only corrections, changes and missing information

1) Degree:
MD

2) Massachusetts Board of Registration No.:
236470

3) DEA No. (If possessed):
B56895695

4) Name:
TIMOTHY P SPURRELL

First: _____ Middle: _____
Last: _____ Suffix: (e.g. Jr., Sr., II, III.)

5) Business Address:
redacted

Applications that include a P.O. Box number without a street address cannot be processed. Out-of-state addresses require a letter of explanation.

City _____ State _____ Zip _____

6) Business Telephone No.:
redacted

(_____)
area code

7) Social Security No.:

Required by M.G.L. c. 30A, s. 13A

8) Drug Schedules requested:
II,III,IV,V,VI

Check all that apply: II III IV V VI
Schedule VI includes all prescription drugs not in Schedules II - V.

In the boxes below enter the requested information

9) Have you ever been convicted of any violation of State or Federal law relating to the manufacture, possession, distribution or dispensing of controlled substances? Yes * No

10) Has any previous professional license or registration held by you under any name or corporate legal entity been revoked, suspended or denied or is it pending such action? Yes * No

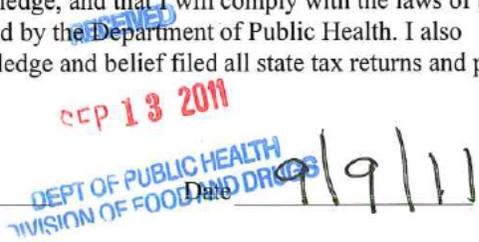
* If you answered "Yes" to Question No. 9 or No. 10, a letter must be attached setting forth circumstances of such action(s).

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, in accordance with M.G.L. c. 62C, 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)

[Handwritten Signature]



COMMONWEALTH OF MASSACHUSETTS

Board of Registration in Medicine



Active License

Timothy P Spurrell M.D.

redacted

Lic. # 236470

Expires: 02/16/2013

The Commonwealth of Massachusetts

DEPARTMENT OF PUBLIC HEALTH, DRUG CONTROL PROGRAM

99 CHAUNCY STREET, 11TH FLOOR, BOSTON, MA 02111

REGISTRATION

in Accordance with Massachusetts General Laws Chapter 94C



NUMBER

ISSUED

TYPE

MS1082899A

04/03/2017

CONTROLLED SUBSTANCES PRACTITIONER

SCHEDULES

II,III,IV,V,VI

ISSUED TO SPURRELL, TIMOTHY P MD

redacted

COMMISSIONER OF PUBLIC HEALTH

FILE COPY

748210

NEW REGISTRANT





Commonwealth of Massachusetts
Department of Public Health, Bureau of Health Professions Licensure
Drug Control Program
239 Causeway Street, Suite 500, Boston, MA 02114
Telephone 617-973-0949 Fax 617-753-8233

Application for Massachusetts Controlled Substances Registration for
Physicians, Dentists, Podiatrists and Osteopath

Please be sure to:

- Complete the first and second page of the application form.
- Sign and date the second page of the application form.
- Enclose check or money order for \$150.00 made payable to "Commonwealth of Massachusetts".
- Mail the completed application to the address above.

The Department will make every effort to process your application as quickly as possible. Please note that processing may take 10 business days from receipt of application. Incomplete applications will be returned and will cause a delay in receiving your MCSR. For further information, visit: <http://www.mass.gov/dph/dcp>.

Application Type: (Select one) New Additional Location Recall

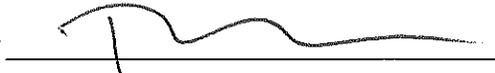
In the boxes below enter the requested information.

1) Degree: (Select one)	<input checked="" type="checkbox"/> M.D. <input type="checkbox"/> D.M.D. <input type="checkbox"/> D.D.S. <input type="checkbox"/> D.O. <input type="checkbox"/> D.P.M.		
2) Massachusetts Board of Registration License No.:	236470		
3) DEA Federal Controlled Substance Registration No. (If possessed). Out-of-state DEA registration numbers require a letter of explanation:	FS1741760		
4) List additional DEA numbers and DEA "X" numbers used on prescriptions that might be dispensed in MA pharmacies.			
5) Name:	First: TIMOTHY Middle: PATRICK Last: SPURRELL		
Suffix: (e.g. Jr., Sr., II, III)			
6) Business Address: Applications that include a P.O. Box number without a street address cannot be processed. Out-of-state addresses require a letter of explanation.	redacted		
Facility Name and Department (if applicable):	redacted		
Street:	redacted		
City:	State:	ZIP:	
7) Mailing Address: <input checked="" type="checkbox"/> Check here if same as above			
Street:			
City:	State:	ZIP:	
8) Business Telephone:	redacted		
9) Social Security Number (Required by M.G.L. c. 30A s. 13A):	redacted		
10) Drug Schedules requested: Select all that apply:	<input checked="" type="checkbox"/> II <input checked="" type="checkbox"/> III <input checked="" type="checkbox"/> IV <input checked="" type="checkbox"/> V <input checked="" type="checkbox"/> VI		
Schedule VI includes all prescription drugs not in Schedules II - V. Only Schedules that are checked can be authorized.			
11) Individual e-mail Address:	redacted		
12) Have you ever been convicted of any violation of State or Federal law relating to the manufacture, possession, distribution or dispensing of controlled substances?	<input type="checkbox"/> Yes * <input checked="" type="checkbox"/> No		

13) Has any previous professional license or registration held by you under any name or corporate name or legal entity been surrendered, revoked, suspended or denied or is such action pending? <input type="checkbox"/> Yes * <input checked="" type="checkbox"/> No
* If you answered "Yes" to Question No. 12) or No. 13), a letter must be attached setting forth circumstances of such action(s).

Applicant please sign and date below

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, in accordance with M.G.L. c. 62C, 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) * 

Date * 3/9/17

VOID VOID
VOID VOID

redacted

redacted

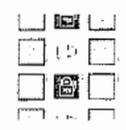
redacted

566592

CHECK DATE	CONTROL NO.	AMOUNT
3/29/2017	566592	\$150.00

PAY One Hundred Fifty and 00/100----- US

TO THE COMMONWEALTH OF MASSACHUSETTS
ORDER
OF



Toby Kelley

AUTHORIZED SIGNATURE

Security features. Details on back

redacted

