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PROFESSIONAL REGULATION

(DO NOT USE THIS APPLICATION FOR RENEWAL OF AN EXISTING LICENSE)

# APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

***DO NOT SUBMIT APPLICATION UNTIL A PERMANENT PRACTITIONERS LICENSE HAS BEEN ISSUED. CONTROLLED SUBSTANCES LICENSE WILL NOT BE ISSUED TO A TEMPORARY LICENSE HOLDER!***

**NOTICE:** Completion of this form is required by ...et. seq. (Illinois Compiled Statutes). Disclosure ... is mandatory. Furnishing by applicant of false or ... information or failure to provide pertinent information ...utes grounds for denying such application or revoking any ...stration issued pursuant to such application.

1. Every person who prescribes or dispenses any controlled substances within the State of Illinois must obtain a license issued by the Department of Professional Regulation in accordance with the Illinois Controlled Substances Act.
2. A separate controlled substances registration is required for each place of professional practice or business where controlled substances are stored or located.
3. A State Controlled Substances Registration is prerequisite to a Federal Controlled Substances Registration.

A. Type or print legibly with black ink only.

B. The fee is $5 - Make check payable to the Department of Professional Regulation. THIS FEE IS NOT REFUNDABLE ...n/fee is required for each r...

C. Disclosure of your L... This disclosure is m... social security num... assist in the identific... in complying with a... ...datory. ...5. The ...Aid to ...nquent

ZITE, NIKKI BETH MD
3036 file# 68671 06-05-02
By: NON-EXAM ASG: wnolan
SSN: [redacted]
JUN 0 6 2002

D. Submit application...
Department of F...
320 West Wash...
Springfield, Illinc...

3[redacted]8

**CHECK A BOX INDICATING THE APPROPRIATE INFORMATION F...**
*(Do not use this form to renew existing Regi...)*

☒ First Time Applicant ☐ Additional Location (separate office where drugs are stored)

## PART I: Application Category Information

| 1. PROFESSIONAL NAME | 2. PROFESSIONAL CODE - Check applicable box | | 3. LICENSURE METHOD | 4. FEE |
|---|---|---|---|---|
| Controlled Substances | ☐319 Dentist | ☒336 Physician | Registration | $5 |
| | ☐316 Podiatrist | ☐390 Veterinarian | | |

## PART II: Applicant Identifying Information

| 1. NAME LAST | FIRST | MIDDLE | 2. TITLE (e.g., M.D., O.D., etc.) | 3. UNITED STATE SOCIAL SECURITY NO. |
|---|---|---|---|---|
| ZITE | NIKKI | BETH | M.D. | [redacted] |

4. PERMANENT MAILING ADDRESS [redacted] CITY STATE/COUNTRY ZIP CODE [redacted] COUNTY [redacted]

5. NAME OF BUSINESS AND LOCATION (STREET/CITY /ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED
Department of Obstetrics and Gynecology
mc 808
College of Medicine
820 S. Wood Street
Chicago IL 60612+7313

6. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S) [redacted]

7. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY
Work (312) 413-5772 scheduled to start 8/1/02
Home ([redacted])

## PART III: Professional Activity

Practitioner - Check and complete one of the following.

| | Professional License Number |
|---|---|
| ☐Dentist | 019 - |
| ☒Physician | 036 - 106545 |
| ☐Podiatrist | 016 - |
| ☐Veterinarian | 090 - |

Drug Schedule: (Circle the schedules for which you are applying)
(II) (IIN) (III) (IIIN) (IV) (V)

**FOR OFFICIAL USE ONLY** FEE $5

**BNDD Number:** | | | | | | | | | |
**Type:** | |
**Suffix:** | |
**Additional Function:** A
**Card Code:** K
**Schedule Codes:** | | | | | | | |
**Issuance Date (Month/Day/Year)** | | | — | | | — | | | | |

| PART IV: Personal History Information *(This part must be completed by all Applicants)* | YES | NO |
|---|---|---|
| 1. Have you ever been charged or convicted of any drug related criminal offense in any state or in federal court? *If yes, attach a statement for each conviction including dates and place of conviction, nature of the offense and if applicable, the date of discharge from any penalty imposed.* | | X |
| 2. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.* | [redacted] | |
| 3. Have you been denied a professional license or permit or privilege of taking an examination, or had a professional license or permit ever disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.* | | X |
| 4. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.* | | X |
| 5. Has any previous registration held by the applicant under the Controlled Substances Act been surrendered, suspended, revoked, denied, placed on probation, or is pending action? *If yes, attach a detailed statement for each action, including dates and place of incident, and the nature of the offense.* | | X |

## PART V: Child Support Information (*This part must be completed by all applicants.*)

Every licensee is required by law to respond to the following question regardless of whether or not he or she is subject to a child support order:

Are you more than 30 days delinquent in complying with a child support order?
*(NOTE: If you are not subject to a child support order, answer "no.")*

☒ NO ☐ Yes

In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

## PART VI: Certifying Statement

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

5/23/02
Date of Application

NIKKI ZITE
[redacted]

**I UNDERSTAND THAT FEES ARE NOT REFUNDABLE.** My signature above authorizes the Department of Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

***Application must be completed in its entirety.***
***If not completed, it will be returned to the address noted on front of application.***



NAME (Last, First, MI): ZITE, NIKKI B
SS#: [redacted]
Profession: physician