

SUBJECT: **PROVIDER AGENCY MEDICAL DIRECTOR
NOTIFICATION OF CONTROLLED DRUG
PROGRAM IMPLEMENTATION**

REFERENCE NO. 702.1

**PROVIDER AGENCY MEDICAL DIRECTOR NOTIFICATION
OF CONTROLLED DRUG PROGRAM IMPLEMENTATION**

I _____ am a physician licensed by the State of California to practice medicine, and authorized by the U.S. Department of Justice - Drug Enforcement Administration to purchase schedule II - IV controlled drugs. My DEA registration number is _____.

I have current knowledge of all Federal, State and County Regulations governing controlled drug procurement and administration and will assume total responsibility for the controlled drug "program" at _____, Fire Department/Approved ALS Provider Agency, including but not limited to, procurement, storage, control, safeguards, recordkeeping, disposal, and inventory.

Physician

Fire Chief/CEO/President

Signature

Signature

Printed Name

Printed Name

Date

Date