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