

Osteopathic Physician Dispensing Application



**Board of Osteopathic Medicine
P.O. Box 6330
Tallahassee, FL 32314-6330**

Website: <https://floridasosteopathicmedicine.gov/>

Email: info@floridasosteopathicmedicine.gov

Phone: (850) 245-4161

Fax: (850) 412-2684



Important Florida Statutes and Rules for Dispensing

Below is a list of Florida laws and rules relevant to dispensing.

Florida Statutes	Florida Administrative Code
456.035	64B15-14.004
456.42	64B15-14.005
456.069	64B15-14.0051
465.185	
465.0276	
499.005	
499.007	
499.028	
499.0054	
893.04	
893.07	

Review Florida Statutes at <http://www.leg.state.fl.us/statutes/>.

Review Florida Administrative Code at <https://www.flrules.org/gateway/Division.asp?DivID=306>.

In addition to the statutes and rules above, section (s.) 459.0137, Florida Statutes (F.S.), s. 459.013, F.S., s. 459.015, F.S., apply to practitioners who practice in a pain management clinic.



Osteopathic Physician Dispensing Registration

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Do Not Write in this Space
For Revenue Receiving Only

Practitioners may not begin dispensing until this registration has been approved. A dispensing practitioner shall not dispense a controlled substance listed in Schedule II or III as provided in s. 893.03, F.S., unless exempted from this section by s. 465.0276, F.S.

Dispensing is defined as the transfer of possession of medicinal drugs from a physician to a patient in the office. A practitioner who writes prescriptions or provides medicinal drugs labeled as "drug sample" or "complimentary drug" is not a "dispensing practitioner," and therefore does not need to register with the department.

Dispensing Fee (non-refundable) \$100.00 An annual inspection of your dispensing records will be conducted.
Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health.

Name: _____ **Date of Birth:** _____
 Last/Surname First Middle MM/DD/YYYY

Florida License Number: OS _____

Primary Practice Location: (Medicinal drugs will be dispensed at the following locations: (attach additional sheets if needed))

Facility Name _____

Street _____ Suite No. City _____

State _____ ZIP _____ Telephone (Input without dashes) _____

Secondary Practice Location: (Medicinal drugs will also be dispensed at the following locations: (attach additional sheets if needed))

Facility Name _____

Street _____ Suite No. City _____

State _____ ZIP _____ Telephone (Input without dashes) _____

Attach additional sheets if you practice at more than two locations.

I certify that the information on this form is true and correct. I dispense medicinal drugs for a fee from the provided practice location(s) and understand that an annual inspection of dispensing records will be conducted.

Signature _____ Date _____
 You may print out this application and sign it or sign it digitally. MM/DD/YYYY

Cancel my dispensing registration effective: _____
 MM/DD/YYYY



Osteopathic Physician Dispensing Registration

Board of Osteopathic Medicine
4052 Bald Cypress Way, Bin C-06
Tallahassee, FL 32399-3257
Fax: (850) 412-2684

Email: info@floridasosteopathicmedicine.gov

Adding/Deleting Dispensing Locations

Name: _____			Date of Birth: _____	
Last/Surname	First	Middle	MM/DD/YYYY	
Florida License Number: OS _____				
Primary Practice Location: Add Delete				
_____ Facility Name				
_____ Street			_____ Suite No. City	
_____ State		_____ ZIP	_____ Telephone (Input without dashes)	
Secondary Practice Location: Add Delete				
_____ Facility Name				
_____ Street			_____ Suite No. City	
_____ State		_____ ZIP	_____ Telephone (Input without dashes)	
Attach additional sheets if necessary.				

I certify that the information on this form is true and correct. I dispense medicinal drugs for a fee from the provided practice location(s) and understand that an annual inspection of dispensing records will be conducted.

Signature _____ Date _____
You may print out this application and sign it or sign it digitally. MM/DD/YYYY

Cancel my dispensing registration effective: _____
MM/DD/YYYY