2000 WEST 135TH STREET, GARDENA, CA 90249 P (800) 438-2568, F (310) 220-2917,

INFO@DVMED.COM, WWW.DVMED.COM

"Know Your Customer" DEA Questionnaire

*** Please fill out completely. Questionnaires returned with blank spaces or unanswered questions will be returned for completion. ***

Section 1: General Information

1. Legal Business Name and DBA (if any): ____Account Number(4digits): ___________

2. Has the registered business ever operated under a different name? ☐YES ☐NO List name(s)______________________________

3. Business Shipping Address: ____________________________City:______________________State:__________Zip Code:_________

4. Type of Business: ☐Medical Office ☐ Veterinary ☐Dentistry ☐Other-Explain_____________________________________

5. Owner's name/s: ____

6. Are you corporately owned? ☐YES ☐NO If yes, list name: ____

7. Does any of the owner/s operate or own any other business YES ☐NO ☐ If yes, list name: ________________________________

8. Is owner a licensed practitioner? ☐YES ☐NO

9. Is owner practicing at the registered location? ☐YES ☐NO

10. Number of years in business: _________

11. Days & hours of Operations:
☐Monday __-__ ☐ Tuesday __-__ ☐ Wednesday __-__ ☐ Thursday __-__ ☐ Friday __-__ ☐ Saturday __-__ ☐ Sunday __-__

Section 2: Practitioner/s Information

12. Total practitioners on staff___________

13. Primary practitioner who will sign Schedule II order forms _____________________________

14. Are you registered with CSOS? ☐YES ☐NO

15. Name of individual(s) who is responsible for controlled substance purchasing, reporting, record-keeping, security:____________

16. Please list all practitioners who will order CS from DV Medical Supply. **Address on DEA License must match to the business ship to address.**

DEA Registrant Name	DEA registration Number	Expiration Date	Check all applicable schedules	State Controlled Substance License Number (if applicable)	Expiration Date	State License Number	Expiration Date
1.			☐2 ☐2n ☐3 ☐3n ☐4 ☐5				
2.			☐2 ☐2n ☐3 ☐3n ☐4 ☐5				
3.			☐2 ☐2n ☐3 ☐3n ☐4 ☐5				

*Attached additional sheet if necessary

Section 2: Prior History

2000 WEST 135TH STREET, GARDENA, CA 90249 P (800) 438-2568, F (310) 220-2917,
INFO@DVMED.COM, WWW.DVMED.COM

17. Last inspection date by DEA:__________________State:_____________________Other(Agency)___________________________

18. To your knowledge, is registrant or any practitioner/employee currently under investigation by any licensing authority, including the DEA? ☐YES ☐NO

- If yes, provide details (including additional sheets if necessary): ____

____

19. Has registrant or any practitioner/employee had a license or registration denied, suspended, or revoked by a regulatory agency?
☐YES ☐NO

- If yes, provide details (including additional sheets if necessary): ____

____

20. Has any practitioner associated with the facility ever been sanctioned by a regulatory agency?
☐YES ☐NO

- If yes, provide details (including practitioner name and license number): ____

SECTION 3: Ordering/dispensing

21. How often are controlled substances ordered? ☐Daily ☐Weekly ☐Monthly ☐Other: ______

How many of each?
1. Schedule II, IIN: 2. Schedule III, IIIN: 3. Schedule IV: 4. Schedule V: 5. Legendary drugs: 6. OTC:

22. List the top five controlled substances administered/dispensed to patients in the office?

1. 2. 3. 4. 5.

23. Approximately how many patients are seen daily? _________

24. Approximately how many patients are treated or administered controlled substances in office per day? _________

25. Do you dispense medications to patients on premises? ☐YES ☐NO

26. Do you have a website? ☐YES ☐NO __________________________

- If yes, do you offer pharmaceuticals (legendary drugs and/or controlled substances) to the general public? ☐YES ☐NO

27. Do you sell any products to other facility/practitioners? If yes, provide reason: ____

28.Do you buy controlled drugs from another wholesaler/s? s: ☐YES ☐NO

Any changes in ownership, location, practitioner-in-charge shall be reported to the staff at DV Medical Supply, Inc. immediately. Customer agrees and understands D-V Medical Supply may provide a copy of this questionnaire to the DEA, other Federal and State regulatory agencies where appropriate. I declare under penalty of perjury that the foregoing is true and correct:

______________________	______________________	__________	__________
Signature	Print Name who completed questionnaire	Title	Date

Please Email or Fax in the completed form and copies of all licenses to SALES@DVMED.COM or Fax: 310-220-2917