NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Narcotic Enforcement

Certificate of Need to Possess Hypodermic Syringes and Needles

This certificate is for "Educational Institutions…and persons engaged in Commercial, Industrial, or Agricultural Activities." Hobbyists and personal pet owners are NOT eligible. This application is for the purpose of establishing your qualifications under Section 80.133 of Title 10 Regulations which can be viewed online at http://www.health.state.ny.us/regulations. You must indicate all proof of engagement in a business enterprise.

COMPLETE ALL SECTIONS

1. ACTIVITY TYPE-Check category for which you are applying (Must send proof**)**

EDUCATIONAL INSTITUTION COMMERCIAL ACTIVITY
INDUSTRIAL ACTIVITY AGRICULTURAL ACTIVITY

2. APPLICANT INFORMATION

Name_____D/B/A (If Applicable)_____

Address_____City_____State_____Zip_____

County_____Phone_____

Has a D/B/A Certificate or a Certificate of Incorporation been filed with the County Clerk or the Secretary of State?

Yes Date Filed_____/_____/_____ Copy Enclosed

No

Have you or your business been convicted, fined, censured or had a license suspended or revoked in any administrative or judicial proceeding pertaining to controlled substances or other drugs?

Yes Attach a sheet with complete explanation

No

3. FACILITY INFORMATION

OWNERSHIP INDIVIDUAL - Specify Reason for Need to Possess Hypodermic Syringes and Needles_____

PARTNERSHIP - Give Federal Employee Identification Number used for business or tax purposes_____

CORPORATION - Give Federal Employee Identification Number used for business or tax purposes_____

Date Established___/___/___ Date Acquired by Applicant___/___/___

4. CERTIFICATIONS-List all licenses, certificates or registrations you or your business currently hold

ISSUING AGENCY	NUMBER	EXPIRATION DATE
_____	_____	_____
_____	_____	_____

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5. AUTHORIZED INDIVIDUALS

A) Person to be responsible for supervising the use of syringes and needles

Name_____Title_____

B) List the individuals responsible for the custody of syringes and needles

Name_____Title_____

Name_____Title_____

(Attach additional sheet with names and titles if necessary)

C) Specify location where syringes and needles will be used_____

_____

D) Purpose for the use of syringes and needles_____

_____

E) Indicate the maximum annual usage of Syringes_____Needles_____

6. SECURITY OF SYRINGES AND NEEDLES

A) Identify type of cabinet to be used for storage of syringes and needles_____

B) Identify location of cabinet_____

C) Identify type of locks to be used_____

7. CERTIFICATE OF APPLICANT

Under the penalties of perjury, I affirm that the statements herein are true and that I will comply with NYCRR Title 10, Section 80.133 of New York State Rules and Regulations.

Print Name_____

Signature_____

Title_____ Date_____/_____/_____

Mail completed form to: Bureau of Narcotic Enforcement
Riverview Center
150 Broadway
Albany, New York 12204
1-866-811-7957 (Option #3)