MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
Bureau of Health Systems

APPLICATION FOR A STATE OF MICHIGAN SUBSTANCE ABUSE LICENSE
(For use of Methadone or Other Controlled Substances in the Treatment of Narcotic Addiction)

Division of Licensing & Certification

☐ Initial Application

☐ Renewal Application Program License No. _____

DATE SUBMITTED _____

LEGAL NAME OF PROGRAM _____

STREET ADDRESS _____

CITY _____ ZIP _____ COUNTY _____ PHONE _____

PROGRAM DIRECTOR'S NAME _____

HOME ADDRESS _____

PLEASE CHECK IF CHANGE IN PROGRAM: ☐ NAME ☐ ADDRESS ☐ PHONE NUMBER

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1. In accordance with provisions of Act 368, 1978, as amended and Administrative Rules (R 325.14101 - R 325.14928) of the Michigan Department of Community Health, Substance Abuse Licensing Section, the undersigned hereby applies for a substance abuse license to utilize methadone or other controlled substances in the treatment of narcotic addiction.

   I understand that I must secure the following approvals before I may operate a narcotic addict treatment program; State Methadone Authority* approval (from the Department of Community Health, Bureau of Substance Abuse Services), Federal Food and Drug Administration and the Federal Drug Enforcement Administration, and licensure by the Substance Abuse Licensing Section to provide outpatient, inpatient, or residential services.

2. Please indicate staff physician(s) name(s) and license number(s).

   Name _____ License Number _____

   Name _____ License Number _____

   Name _____ License Number _____

*State Methadone Authority as defined in 21 CFR, September 16, 1977, Part 291, Section 291.505(a)(4)

BHS-LC-102 (Rev. 12/09)
Authority: P.A. 368 of 1978, as amended

The Michigan Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. You may make your needs known to this agency under the *Americans with Disabilities Act* if you need assistance with reading, writing, hearing, etc.

3. Please indicate each physician's previous employment experience with methadone programs.

_____

_____

_____

4. Please indicate each physician's schedule of on-site hours:

_____

_____

_____

5. If the program will utilize physician's assistants, please list their name(s) and license number(s).

Name _____ License Number _____
Name _____ License Number _____
Name _____ License Number _____

a. Supervision of the physician's assistants will be the responsibility of the following licensed physician(s).

Physician _____ Physician's Assistant _____
Physician _____ Physician's Assistant _____
Physician _____ Physician's Assistant _____

b. The Physician's Assistant Committee, Department of Community Health ☐ has ☐ has not been notified and approval ☐ has ☐ has not been received for the individuals listed above to function as physician's assistants at our program.

c. The Medical Practice Board, Department of Community Health ☐ has ☐ has not provided approval for the above listed physicians to supervise the above named physician's assistants.

6. Indicate the hours the program provides the following services:

Medication _____
Counseling _____

7. If comprehensive physical exams will not be completed on-site, please provide the name and address of the clinic, hospital, or physician with whom you have contracted to provide this service.

Name _____
Address _____

8. Indicate the name and address of the laboratory or laboratories providing urinalysis and other laboratory services.

Name _____

Address _____

Service Provided _____

Name _____

Address _____

Service Provided _____

9. Attach a description of the intake procedure and admission/eligibility criteria for methadone patients, including the length of time the intake procedures will take. If this procedure is described in Item 7 of the license application, then attach only the admission/eligibility criteria for methadone patients. If this is a renewal application, attach only a description of any changes in procedures or criteria from last year's application materials.

10. Please provide the name and address of the supplier of methadone to your program.

Name _____

Address _____

11. Please indicate in which form the methadone arrives at your program.

☐ Bulk liquid ☐ Bulk powder ☐ Methadose

12. Methadone ☐ is or ☐ is not prepared into doses on-site. If methadone is **not** prepared into doses on site, indicate the name and address of the compounder and describe the delivery procedure.

_____

_____

_____

_____

If methadone **is** prepared into doses on-site, please indicate the pharmacist's name and license number.

Name _____ License Number _____

13. Please indicate if your program plans to act as a supplier of methadone to any other program.

☐ YES ☐ NO

If YES, indicate the legal name and address of that program:

Name _____

Address _____

14. Please indicate the name of the **program sponsor** as reported to the Federal Food and Drug Administration.

Name _____

NOTE: Programs that have ongoing exchanges of client identifying information with other organizations (as in Items 7, 8, 12, & 13) may need to enter into a Qualified Service Organization Agreement as specified in Section 2.11(n) of the Federal Regulations on Confidentiality of Alcohol and Drug Abuse Patient Records, July 1, 1975.

CERTIFICATIONS

As program director, I certify that I am responsible to the governing authority of this program or its authorized agent for over-all operation of the program. I have reviewed Article 6 of Public Act 368 and the administrative rules applicable to the service or services provided by my program. I believe my program is in compliance with the rules and the act and is ready for an on-site inspection.

I further certify that the information furnished on this application is true and accurate. Any information found to be false may result in my application being denied or my program licensure being revoked. Supportive documentation will be furnished upon request of the Substance Abuse Licensing Section or the coordinating agency designated to serve my program's geographic area.

By signing this application for license, I certify that should any information contained in this application change, notice of the change will be immediately provided to the Substance Abuse Licensing Section. Failure to do so may invalidate the license.

SIGNED _____ Date _____

Program Director

As the duly authorized representative of the applicant program's governing authority, I certify that the governing authority has the authority and responsibility for over-all operation of the program and will ensure that the program complies with applicable licensing standards.

SIGNED _____ Date _____

Governing Authority Representative

TITLE _____

Mailing Address:
Michigan Department Of Community Health
Bureau of Health Systems; Division of Licensing & Certification
Substance Abuse Licensing Section
P.O. Box 30664; Lansing, Michigan 48909