

Michigan Department of Licensing and Regulatory Affairs  
 Bureau of Health Care Services  
 Health Facilities Division  
**Substance Abuse Program**  
 P.O. Box 30664  
 Lansing, MI 48909  
 (517) 241-1970  
Authority: P.A. 368 of 1978, as amended

Program License Number:
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**APPLICATION FOR A SUBSTANCE ABUSE LICENSE**

**(For use of Methadone or Other Controlled Substances in the Treatment of Narcotic Addiction)**

Initial Application                      Renewal Application                      Date Submitted: \_\_\_\_\_

**Please Check if change in program:**      Name              Address              Phone Number

**PLEASE TYPE OR PRINT CLEARLY**

Program Legal Name			Program License Number	
Street Address (P.O. Box, if applicable)				
City	State	Zip Code	County	
Telephone Number with Area Code	Fax Number with Area Code	E-Mail Address		

Program Director's Name				
Program Director's Street Address (P.O. Box, if applicable)				
City	State	Zip Code	County	

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 Licensing and Regulatory Affairs, Substance Abuse Program, 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 Program 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)

The Michigan Department of Licensing and Regulatory Affairs 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 Licensing and Regulatory Affairs has not been notified and approval 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 Licensing and Regulatory Affairs 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 Program 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 Program. Failure to do so may invalidate the license.

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Signature blocks can be typed for electronic submission of form and has the same force and effect as a written signature.)*

Printed Name: \_\_\_\_\_  
*(Written signatures must also include printed name.)*

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: \_\_\_\_\_  
*(Signature blocks can be typed for electronic submission of form and has the same force and effect as a written signature.)*

Printed: \_\_\_\_\_  
*(Written signatures must also include printed name.)*

Title: \_\_\_\_\_