Proficient Rx LP
3607 Old Conejo Road
Thousand Oaks, CA 91320
Phone: (800)787-7824
Fax: (800)626-5004

Proficient Rx Regulatory Questionnaire

Proficient Rx is committed to the strict adherence of all State and Federal Drug distribution and dispensing regulation requirements. The FDA and DEA regulations require that we certify the practitioners we distribute prescription controlled and non-controlled medications to. To ensure strict compliance with State and Federal regulations Proficient Rx requires all customers to complete this Regulatory Questionnaire. This form will be used by regulatory management for account evaluation and review purposes.

Practice Information

Business Name: _____

Address where dispensing will occur:

Street: _____ City: _____ State: _____

Zip Code: _____

Phone: _____ Fax: _____

Office Contact: _____

Email Address: _____

Days and hours of Operation at this location. Let us know if you are at the location on those days using the dropdown button

☐ Mon – hours: _____ ☐ Tue – hours: _____ ☐ Wed – hours: _____ ☐ Thu – hours: _____

☐ Fri – hours: _____ ☐ Sat – hours: _____ ☐ Sun – hours: _____

Are all applicable State, Federal, local licenses current and are they issued for the registered address at which the practice is/will be dispensing? ☐ Yes ☐ No

Type of practice: Check all that apply

☐ Work Comp ☐ Family Practice ☐ Dental ☐ Urgent Care ☐ Other: _____

How many years has this practice been operating? _____

Practitioner Information

Supervising Practitioner: _____

DEA #: _____ State License #: _____

Do you plan to purchase and dispense controlled medications? ☐ Yes ☐ No

If Yes, please check all schedules that apply: ☐ C-II ☐ C-III ☐ C-IV ☐ C-V ☐ L-I

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Copies of your current **State Medical License** must be submitted with your account paperwork. If you will be dispensing Controlled Medications you must also provide a copy of your **DEA License** as well. DEA License address must match the address where medications will be shipped to and where meds will be dispensed.

Is there more than one practitioner dispensing at this location? ☐ Yes ☐ No

Please list any additional practitioners practicing at this location:

1. Name:_____ DEA #: _____ State Lic #: _____
2. Name:_____ DEA #: _____ State Lic #: _____
3. Name:_____ DEA #: _____ State Lic #: _____
4. Name:_____ DEA #: _____ State Lic #: _____
5. Name:_____ DEA #: _____ State Lic #: _____

Practice Drug Survey

Please complete the following questions in their entirety.

1. Estimate the average # of patients **seen** per week: _____
2. Estimate the # of patients that will be **dispensed** to per week: _____
3. Does this practice currently Dispense? ☐ Yes ☐ No

   (If no, please give estimates for questions **a, b** and **c.)**

   a. Average # of bottles dispensed per week: _____
   b. Of the above #, what % are controlled medications: _____ %
   c. What % are Non-Controlled medications: _____ % (The total of **b** and **c** should equal 100%)
4. Do you engage in out of state prescribing? ☐ Yes ☐ No
5. Do you engage in out of state dispensing? ☐ Yes ☐ No
6. Are dispensing records being adequately maintained? ☐ Yes ☐ No
7. Are the state-mandated reports being submitted properly? ☐ Yes ☐ No ☐ N/A
8. Is DEA form 106 (to report lost/stolen controlled substances) presently being used? ☐ Yes ☐ No ☐ N/A
9. Have the facility or practitioner licenses ever been revoked, suspended or put on probation? ☐ Yes ☐ No

   a. If yes, please submit official documentation as to the incident and current status of the license.
10. Are you currently using another supplier to purchase medications? ☐ Yes ☐ No ☐ N/A

    a. If yes, please provide suppliers name: _____
11. Do you perform background checks and drug screens on employees? ☐ Yes ☐ No
12. Have you experienced theft or loss of medications? ☐ Yes ☐ No
13. Are medications dispensed and/or transferred at other locations? ☐ Yes ☐ No ☐ N/A

    a. If yes, to what other location? _____
14. Does the practitioner conduct random unannounced drug testing for patients? ☐ Yes ☐ No

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15. Do you dispense or prescribe without having face to face contact with the patient? ☐ Yes ☐ No
16. Do you sell any controlled substances online? ☐ Yes ☐ No ☐ N/A
17. What measures does the practitioner employ and/or monitor to prevent patient addiction to controlled substances?

_____

_____

18. What measures does the practitioner employ and/or monitor to prevent diversion of Rx medications?

_____

_____

19. Does the practitioner have an additional office that he/she practices and/or dispenses out of? ☐ Yes ☐ No
    a. If yes, please explain: _____

_____

20. If your medical facility is seasonal please indicate an explanation of your practice and your busiest months of the year:

_____

_____

Security Questionnaire

1 .What type of security features are currently utilized at this facility?

☐ Daily ☐ Locked Cabinet(s) ☐ Security Camera(s) ☐ Other: _____

2. Is there a security guard on site? ☐ Yes ☐ No
3. Is access to controlled substances restricted to authorized individuals only? ☐ Yes ☐ No ☐ N/A
4. Drug Access: (List all who will have access to controlled substances other than practitioners.)

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

5. Does the practitioner currently order for himself/herself or for the clinic? ☐ Him/Herself ☐ Clinic

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Prescription/Controlled Product Authorization

I,_____(Licensed Medical Professional) authorize the following personnel to purchase/receive prescription products and needles/syringes on my behalf: _____

_____

I understand that it is my responsibility and the responsibility of my practice to adhere to any state and/or federal laws regarding drug labeling.

Initial Here: _____

It is my responsibility and the responsibility of the establishment to comply with all State and Federal rules related to the storage and dispensing of pharmaceuticals.

Initial Here: _____

It is my responsibility and the responsibility of the establishment to comply with all State rules pertaining to the reporting of controlled substances dispensed in office.

Initial Here: _____

Practitioner Signature: _____

DEA #: _____ (must match shipping address)

Office Use Only

Is the Facility clean? ☐ Yes ☐ No Is the facility secure? ☐ Yes ☐ No

Does the facility provide adequate space to store medications? ☐ Yes ☐ No

Does the facility provide adequate security to store dangerous drugs and/or devices? ☐ Yes ☐ No

Approved:_____ Approved for Controlled Substances: _____

Additional Regulatory Direction Provided: _____

Proficient Rx Representative:

Print Name:_____Signature:_____ Date: _____

If you have documentation to submit after completing this form please call our number on this form to find out how to submit your documents