



NOTICE OF INTENT TO DISPENSE DRUGS

At the time of license renewal, licensed Podiatrists are required to notify the Georgia State Board of Podiatry Examiners of their intention to dispense drugs if he or she desires to dispense any drugs and/or controlled substances as defined in Article 2 of Chapter 13 of Title 16 [O.C.G.A. §§ 26-4-130(a)(1) & (2); 26-4-130(e)]. This form is designed to satisfy this requirement of the law.

ALL LICENSED **PODIATRISTS** ARE TO SUBMIT THIS FORM IF:

- ✓ On your license renewal application you answered YES to the question which asked if you have a current DEA License Number and intend to dispense drugs in accordance with the law cited above; or,
- ✓ You obtained a DEA License Number during the biennium (2 year renewal cycle) and intend to dispense drugs in accordance with the law cited above.

Within ten (10) days of your renewal application and/or obtaining your DEA License Number: 1) Complete this form in its entirety, entering N/A where appropriate; and, 2) Submit it to the Board offices by either uploading it at the time of renewal, faxing it to 1-866-888-1308 or emailing it as a PDF attachment ONLY to PLB-Healthcare2@sos.ga.gov.
DO NOT SUBMIT THE FORM USING MULTIPLE METHODS AS IT CAUSES DUPLICATIVE WORK AND DELAYS PROCESSING.
 If the form is not completed accurately, your renewal may be delayed.

GA Professional License Number: _____ DEA License Number: _____
POD followed by six (6) digits Include all letters and digits

Name of Practitioner: _____
(Last) (First) (Middle) (Maiden Optional)

Physical Address: _____
(Street Only – NO P.O. Box # Accepted)

(City) (State) (Zip)

Below provide the name and address of the office or facility from which the drugs shall be dispensed.

Name of Office/Facility: _____

Office/Facility Address: _____
(Street or P.O. Box – This address will appear on the public listing of your license)

(City) (State) (Zip)

Are all records pertaining to the drugs maintained at the office/facility entered above? Yes No

If you answered NO to the question above, provide the address where records pertaining to the drugs shall be maintained. _____
(Street Only – NO P.O. Box # Accepted) (City/State) (Zip)

By entering my official signature below, I hereby swear and affirm that all of the information provided on this form and any attachments is true and correct to the best of my knowledge and belief.

Signature of Licensee: _____ Date: _____