



Washington State Department of

Health

Dental Quality Assurance Commission
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

DEA Authorization

Applicant: Please complete the identifying information and submit this form directly to:
Drug Enforcement Administration
Attention: Diversion Unit, Registration
300 5th Ave Suite 1300
Seattle, WA 98104

Applicant Demographics:

First Name	Middle	Last Name
Credential # (If available)		Date of Birth

Applicant Statement

I am applying for a license to practice dentistry in the state of Washington. Please send this form directly to the Dental Quality Assurance Commission Credentialing section.

DEA Registration Number

DEA Registration Number

DEA Registration Number

DEA Registration Number

If you have additional DEA Registration Numbers, please attach another form.

Applicant's Signature _____ Date _____

To be completed by the Drug Enforcement Administration

Applicant has surrendered (for cause) or had a federal controlled substance registration revoked, suspended, restricted, or denied.

Yes No

Initials _____ Date _____

Please mail this completed form to the Dental Quality Assurance Commission Credentialing section at the address listed above, or you can email it to: hsqareview2@doh.wa.gov.