

APPLICATION FOR CONTROLLED SUBSTANCES

Office of Research
1534 White Avenue
University of Tennessee, Knoxville
Knoxville, TN 37996-1529

Date: _____ New: _____ Revision: _____ Renewal: _____ Termination: _____ CSC # _____

Project Title: _____

Principal Investigator: _____ Title: _____

Address: _____ Telephone: _____

Co-Investigators, assistants, technicians (list all persons who may handle materials):

NAME	SSN	DATE OF BIRTH	PLACE OF BIRTH
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Project Term: From: _____ To: _____

Attached Materials (check as applicable)

_____ Protocol or equivalent Description of the Room & Building where the controlled substances will be kept, including:

Construction Type: _____

Number of floors: _____ Description of doors and locks: _____

Alarm Systems: _____ Video Monitoring: _____

General Purpose of the building (lab, classrooms, office space, storage): _____

Brief Description of campus security if present: _____

Name and address of the intended supplier of controlled substances: _____

Name(s) of individual(s) who will have access to lab, or location where controlled substances will be stored:

Legend drugs or controlled substances to be used:

ITEM	QUANTITY	ITEM	QUANTITY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Target Use: Animals _____ Humans _____ (Obtain appropriate review and approval)

Proposed Use of Drug: _____

SIGNATURES:

Department Head Department Principal Investigator

Approved _____
Date Office of Research, Compliances

CSC PROJECT NUMBER: _____

DATE: _____

LEGEND DRUG AND CONTROLLED SUBSTANCE PURCHASE CONTROL FORM

CSC Chemical Control Substance Control Number: _____

Name: _____

UT Address: _____ Telephone Number: _____

Account(s) to be charged: _____

Project Title: _____

CONTROLLED SUBSTANCE (Requires DEA registration also)	MONTHLY AUTHORIZED	TOTAL QUANTITY
_____	_____	_____
_____	_____	_____

LEGEND DRUGS FOR HUMAN/VETERINARY USE

_____	_____	_____
_____	_____	_____

Dollar obligation: _____ Quarterly: _____ Total: _____

NAME AND ADDRESS OF INDIVIDUAL TO RECEIVE COPIES OF ORDERS AND INVOICES:

Date of CSC Approval: _____ Date of Approval Expiration: _____

Instructions to Responsible Investigator: Based upon CSC approval of your project, some of the information has been preprinted on this form. The substances and total quantities which have been authorized for you may not be changed except by application to CSC for modification of your project. Consult with your department head in making arrangements for the method of purchase, selection of vendor, and method of obligating funds. When all information is complete, return this form to the Compliance Officer, 1534 White Avenue (Telephone 974-3466).

Signatures:

Investigator Named Above

Department Head or Unit Director

Department or Unit