Dental Quality Assurance Commisson
PO 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 Ste 1300
Seattle, WA 98104

Applicant Demographics		
First Name	Middle	Last Name
Credential # (if applicable)	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: HSQAReviewDental@doh.wa.gov