

# Instructions for filling out the HPN Medical Professions Account Application Form

This is the New York State Department of Health's HPN Medical Professions Account Application Form to obtain an HPN account. After the information is verified, the HPN Account Application will be sent to you via email to be signed by the practitioner and have notarized. If you need assistance filling out this form, contact the Bureau of Narcotic Enforcement (BNE) at 1-866-811-7957 and select option 1.

- In your browser's address bar, type: <https://commerce.health.state.ny.us/pub>



This page is an introduction to the application.

- Click **Request an HPN Medical Professions account application** link to access the form.

A screenshot of the 'New York State Department of Health Medical Professions Account Request' form. The form asks the user to select a license type from a dropdown menu, with 'Medicine (Physician)' selected. Below this, there are input fields for 'Last name\*', 'First name\*', and 'Current NYS Medical license number\*'. A 'Continue' button is at the bottom. The status bar at the bottom of the browser window shows 'Document: Done (6.513 secs)'.

This page checks that your license type (e.g. Medicine, Dentist, etc.), your last name, your first name, and your NYS medical license number match what is in the State Education Department's (SED) database. If they do not match, you will receive an error message\*.

All fields marked with an asterisk are required.

- Click your license type. You may have to scroll down to locate it.
- Enter your **Last Name** as it is recorded with SED
- Enter your **First Name** as it is recorded with SED
- Enter your **Current NYS License Number**
- Click **Continue**
  - Data entered matches SED's database, you will advance to the next page.
  - Data entered does not match SED's database, you will not be allowed to advance to the next page and receive an error message\*. For assistance, contact BNE at 1-866-811-7957 and select option 1.

**Error: Practitioner and License number do not match. Please correct information.**

\* The error message will appear at the top of the screen.

## Select the box that applies to you

This example has the license number blacked out for security reasons.

- Check the check box that applies to you:
  - I am the primary practitioner of a medical practice (incorporated/partnership/proprietorship)
  - I am not the primary practitioner of a medical practice.
- Click **Continue**.

## Enter your data on this page

A link to the SED's Online Verification Search page is provided for your convenience.

The practitioner's name, license, and license type is populated from the information entered on the previous page. This example has the license number blacked out for security reasons.

Enter the required data in the appropriate fields for the following:

- Business Entity Number (only visible if you are the primary practitioner of a medical practice)
- Name of the Medical Practice (only visible if you are the primary practitioner of a medical practice)
- Mailing address
- City
- State (NY is the default)
- Zip
- Phone number and extension
- Fax number
- Title
- Driver's license number or State Issued Photo ID
- Driver's license state (NY is the default)
- DEA number
- Social Security number (last four digits)
- E-mail address (Format: userid@host.domain)
- Re-enter e-mail address (for verification)
- Month, day and year of birth (Format: mm/dd/yyyy)
- Click **Continue**.

An error message will appear next to fields not filled in and are required.

This page gives you the opportunity to review and modify erroneously entered data

**New York State Department of Health  
Practitioner Account Request Application Form**

Please verify information and click 'submit' on the bottom when done.

[Link to State Education Department professions search page](#)

Required fields are in bold letters with an asterisk.

First Name : **David** Middle : **Raymond** Last Name : **Artz**  
Current NYS Medical License number : **227338** License Type : **Medicine (Physician)**

---

How to look up your State Education Department Business Entity Number Instructions

Business Entity Number \* : 99999999  
Name of the medical practice \* : Test Medical Practice  
Mailing Address \* : 123 Test Street  
City \* : Albany  
State \* : NY  
Zip \* : 12204  
Phone Number \* : 555 555 5555 Ext. : 5555  
Fax Number \* : 555 555 5555

---

Title : MD (i.e. MD, DDS, DVM etc)  
Driver's License number or State Issued Photo ID \* : 123456789  
Driver's License State \* : NY  
DEA Number : AA9999999 (enter your DEA number if you have one, otherwise leave it blank)  
(2 characters or numbers followed by 7 numbers)  
Social Security Number \* : 1234 (last 4 digits)  
E-mail \* : test@email.com  
(Email format: userid@host.domain)  
Re enter e-mail \* : test@email.com  
(Email format: userid@host.domain)  
Month/Day/Year of Birth \* : 09 / 24 / 1965 (Format: mm/dd/yyyy)

By pressing "Submit" below:  
Your request will be reviewed by the NYS Department of Health's Bureau of Narcotics Enforcement and a form will be sent to you shortly via email. If you do not receive the form within 3 business days, please contact the Bureau of Narcotics Enforcement at (866)811-7957 and select option 3 or email [docpbml@health.state.ny.us](mailto:docpbml@health.state.ny.us)

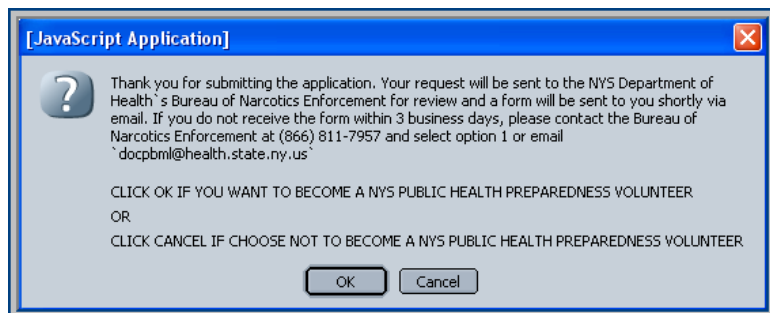
---

Click 'Modify Data' to save any changes you just made  
Click 'Submit' to complete the application request.  
Click 'Go Back' to go to the first page

- To make changes, click in the field, delete incorrect data, enter correct data, and click **Modify Data** to save any changes that you just made; and
- When all the information is accurate, click **Submit** to complete filling out the Practitioner Account Request Application Form.
- To cancel the request, click **Go Back**.

By clicking "Submit":

**Your request will be reviewed by the NYS Department of Health's Bureau of Narcotics Enforcement and a form will be sent to you shortly via email. If you do not receive the form within 3 business days, please contact the Bureau of Narcotics Enforcement at (866) 811-7957 and select option 1 or email [docpbml@health.state.ny.us](mailto:docpbml@health.state.ny.us)**



This is a pop up message thanking you for submitting the application and giving you the opportunity to become a NYS Public Health Preparedness Volunteer.

- Click **OK** if you choose to become a volunteer.
- Click **Cancel** if you choose not to become a volunteer.