

[Date]

To: [Pharmacy Name / DEA Field Office / State Medical Board]
From: [Facility Name / Primary Supervising Provider]
Subject: Temporary Locum Tenens Controlled Substance Authorization

To Whom It May Concern,

This letter serves as formal authorization for **[Locum Tenens Provider Name]**, [Provider Title: e.g., MD, DO, NP, PA], to prescribe and administer controlled substances at **[Facility Name]** located at **[Facility Address]**.

Locum Tenens Provider Credentials:

State Medical License Number: [License Number]
Individual DEA Registration Number: [DEA Number]
NPI Number: [NPI Number]

Authorization Period:

Effective Date: [Start Date]
Expiration Date: [End Date]

During this period, the aforementioned provider is authorized to utilize the facility's DEA registration number **[Facility DEA Number, if applicable]** with the specific suffix **[Suffix, if applicable]** for the purpose of prescribing controlled substances within the scope of their temporary assignment and in accordance with all state and federal regulations.

The provider's identity and credentials have been verified through our medical staff office. Should you require further verification, please contact **[Contact Person Name]** at **[Phone Number]** or **[Email Address]**.

Sincerely,

[Signature]

[Name of Authorized Official]
[Title]
[Facility Name]