



The Commonwealth of Massachusetts
 Department of Public Health, Bureau of Health Professions Licensure
 Prescription Monitoring Program
 250 Washington Street, Boston, MA 02108
 Phone: 617-753-7310 Fax: 617-973-0985

**Massachusetts Request for Waiver of Daily Data Submission
 for Pharmacies Not Open 7 Days a Week**

In Accordance with the Controlled Substances Act, M.G.L. Chapter 94C

Pharmacies that are not open 7 days a week to dispense Controlled Substances in Schedules II-V or any additional drugs that the Department has determined must be reported to the PMP may complete this form to request a waiver of the requirements that pharmacies must report to the PMP every day. Pharmacies must indicate which days of the week they are open and will report to the PMP. Please submit to the Department by July 1st of each year via email to: mapmp.dph@mass.gov

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| Business Type (select one): <input type="checkbox"/> MA Pharmacy <input type="checkbox"/> Out of State Pharmacy <input type="checkbox"/> VA Pharmacy <input type="checkbox"/> Mail Order Pharmacy | Please provide all applicable license number(s) for your facility: <input type="checkbox"/> National Provider Identifier (NPI): <input type="checkbox"/> Drug Enforcement Administration (DEA): <input type="checkbox"/> Massachusetts Board of Pharmacy (MBOP): |
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Pharmacy Days of Operation (select all days that your pharmacy is open to dispense):
 Sunday Monday Tuesday Wednesday Thursday Friday Saturday

| Business Information | |
|--------------------------------------|--------------------------------|
| Business Name: | Facility Name (if applicable): |
| Business Address: | City: ZIP: |
| Business Phone: () - - Ext: | Business Website: |
| Business Contact Name: | |
| Business Contact Phone: () - - Ext: | |
| Business Email Address: | |

| Pharmacist In Charge (PIC) |
|----------------------------|
| PIC Name: |
| PIC Phone: () - - Ext: |
| PIC Email Address: |

| IT/ Software Vendor (if applicable) |
|--------------------------------------|
| Vendor Name: |
| Vendor Product Name/Version: |
| Primary Contact for Software Vendor: |
| Vendor Phone: () - - Ext: |
| Vendor Email Address: |

I hereby certify that the information on this application is true to the best of my knowledge and that my pharmacy does not dispense any controlled substances that must be reported to the PMP on the days that my pharmacy is not open.

Requesting Authority:

| | | |
|-------|------------|-------|
| Name: | Signature: | Date: |
|-------|------------|-------|

DPH Personnel

| | | |
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| Approved by: | Signature: | Date: |
|--------------|------------|-------|

For additional information on pharmacy exemptions please visit: www.mass.gov/dph/dcp/pmp or contact the PMP by telephone: 617-753-7310.