Department of Public Health
Division of Health Care Facility Licensure and Certification
(617) 753 - 8000

Waiver Application for Administration of Controlled Substances

(Please Print or Type)

Fax To: (617) 753-8094	**Facility Name:**	**Tel #**
Attention: **DHCFLC Waiver Processing**	**Address:**	**City/Town:**
	From:	**Fax #**:

Submit by fax your application for a waiver of 105 CMR 150.008(C) (2) (c) to permit a responsible person to administer to a long term care resident a controlled substance not listed in the above regulations. Your application will be reviewed and faxed back to you with the Department's response indicated below.

Resident: Date of birth:

Physician:

Prescription type: ☐ original ☐ renewal
Please send most current physician progress note and most recent nursing assessment for prescription renewals.

Exact Prescription Name:

Dosage (# of mg./tabs)	
How Administered/ Frequency	
Pain/Other	
PRN/Routine	
Refills	
# of Pills:	

Diagnosis related to need for medication:
(please provide a detailed explanation)

Facility Staff Person Requesting this Waiver:

Name: Position

Signature: Date:

Has the staff been in-serviced on the clinical use and adverse effects of the drug(s)?

☐ Yes ☐ No

If "NO" - An in-service will be done on _____ by the following Physician, Nurse or Pharmacist (write his/her name below):
Name:

BELOW IS FOR DEPARTMENT OF PUBLIC HEALTH RESPONSE ONLY

☐ Approved Date:

This approval is contingent upon the following conditions:

1. Approval is for no more than 90 Days from the date of approval.
2. The medication is to be discontinued and appropriately destroyed, if any of the medication remains at the end of 90 days.
3. Administration of PRN medications for pain should be based on the resident's own assessment of need.

☐ Denied Date:

Program Manager:		Date:

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