**WAIVER REQUEST FORM**

**Health Care Facility (Hospital)**

**DPH – DHCFLC, 67 Forest Street, Marlborough, MA 01752**

**NOTE: A SEPARATE WAIVER REQUEST FORM MUST BE SUBMITTED FOR EACH REQUIREMENT TO BE WAIVED.**

Health Care Facility’s (Hospital) Licensed Name MA DHCFLC Hospital License Number

Address, including zip code MA Controlled Substance Registration

Name, if Hospital/Clinic Satellite Address, including zip code

**Request of Waiver of Requirements of 105 CMR 722.080 or 105 CMR 722.090**

**Explain the emergency and how it affects public health and safety (include expected duration of emergency situation):**

**Explain how complying with current regulation(s) (Citation\_\_\_\_\_), as written, is/are a barrier to alleviating the emergency situation:**

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Health Care Facility’s (Hospital) Licensed Name MA DHCFLC Hospital License Number

**Explain how the waiver will enable the facility to address the emergency situation:**

**Assurance of hospital that granting of the waiver WILL NOT JEOPARDIZE/AFFECT PATIENT OR RESIDENT HEALTH AND SAFETY (include national and professional standards implemented for ensuring safety, sterility, quality of pharmaceutical):**

**Assurance of hospital that granting of the waiver WILL NOT JEOPARDIZE SECURE TRANSPORT OF PHARMACEUTICAL AND DRUG SUPPLIES (include description of drug transportation):**

**MA Schedule VI Controlled Substance(s) Included in the Waiver**

**List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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 Health Care Facility’s (Hospital) Licensed Name MA BHCQ Hospital License Number

**I HEREBY REQUEST THAT THE DEPARTMENT OF PUBLIC HEALTH WAIVE COMPLIANCE WITH REGULATION :**

**105 CMR \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FACILITY AUTHORIZED REPRESENTATIVE: FACILITY CLINICAL REPRESENTATIVE:**

Name: Name:

Title: Title:

Mailing: Mailing:

Tel #: Tel#:

Signature: Signature:

**For DPH Use Only:** The waiver identified above is approved, approved with conditions or denied as indicated below.

Evaluated by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ /\_\_\_ /\_\_\_ Approved Approved w/Conditions Denied

Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ /\_\_\_ /\_\_\_ Approved Approved w/Conditions Denied

CONDITIONS:

WAIVER TERMS END DATE:

EXTENSIONS:

**END DOCUMENT**