

Department of Public Health  
Drug Control Program-Medication Administration Program  
Waiver Request – Virtual 2 Person Count & CS Disposal

*The Service Provider for the DPH MAP Registered site must provide the DPH Drug Control Program with sufficient written documentation to support its request for a waiver. Attach additional documents if pertinent.*

MAP Service Provider:		Date:	
DPH MAP Registered Site Address (number and street, town, zip code):		MAP MCSR #:	
		Agency Affiliation (check one)	DCF _____ DDS _____ DMH _____ MRC _____

MAP Policy/Policies for which waiver is requested (check all applicable):	MAP Policy 10-03 <i>Medication Security and Record Keeping for Schedules II-V</i> MAP Policy 10-05 <i>Medication Security and Record Keeping for Schedules II-V Disposal</i>
---	---

A. Has the site implemented the “ <b>COVID-19 Virtual Two-Person Countable Controlled Substances Count</b> ” alternate procedures within the last 48 hours? If yes, on what date did the site first commence using the approved alternate procedures:	
B. Explain and document the undue hardship experienced at the MAP Registered site due to compliance with MAP Policy 10-03 and/or 10-05 (detail why the MAP Registered site is unable to comply with each MAP Policy selected above), and how implementation of the DPH MAP alternative procedures would alleviate that undue hardship. (May attach supplemental document(s), if pertinent):	
C. Explain and document the compensating features the MAP Registered site will put into place if this waiver is granted:	MAP Registered site will implement the approved alternate procedures set out in DPH MAP Procedure “ <b>COVID-19 Virtual Two-Person Countable Controlled Substances Count</b> ” a copy of which is submitted with this application.
D. Explain and document how the MAP Registered site will conduct the on-site, in-person 2 person count, at least once each 7 days, which is a required condition of the requested waiver:	

Service Provider Contact Information		
Name & Title	Email	Telephone:
Street Address, Rm, Suite, etc.	City, State	Zip Code

Signature	Date
-----------	------

Waiver requests, including copies of all supporting documentation, should be submitted via email to:

[MAP.DCP@mass.gov](mailto:MAP.DCP@mass.gov)