|  |
| --- |
| **Department of Public Health****Drug Control Program-Medication Administration Program****Waiver Request Form** |
| *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): | DDS       DCF      DMH      MassAbility      |
| MAP Policy/Policies for which waiver is requested: |       |
| 1. Explain how waiving the above policy would alleviate undue hardship without jeopardizing the health or safety of the individuals supported by the site:
 |       |
| 1. Explain and document the compensating features the DPH MAP Registered site will put into place if this waiver is granted:
 |       |
| Service Provider Contact Information: |
| Name and 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** |