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| **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**](mailto:MAP.DCP@mass.gov) | | | | | |