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:			
2. 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