

**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):	<input type="checkbox"/> DDS <input type="checkbox"/> DCF <input type="checkbox"/> DMH <input type="checkbox"/> MRC		
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:	
<p>Waiver requests, including copies of all supporting documentation, should be submitted via email to:</p> <p>MAP.DCP@mass.gov</p>			