The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
Drug Control Program
250 Washington Street, 3rd Floor
Boston, MA 02108

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www.mass.gov/orgs/massachusetts-controlled-substances-registration

Attestation and Supervising Physician Removal Form

CDTM Pharmacists, Physician Assistant and Advanced Practice Registered Nurses (CNPs, CRNAs and PCNSs): Please note we no longer require your supervising physician or qualified healthcare professional name. You will simply attest to having a supervising physician or qualified healthcare professional with written guidelines. Once you attest, if you wish to remove your supervising physician from your profile, please fill out and submit the 2nd page.

Advanced Practice Providers (PAs, CDTM pharmacists) must have a Supervising Physician in each of their practice settings. APRNs who do not meet the requirements for independent prescriptive practice) must have a Supervising Physician, or Qualified Healthcare Professional in each of their practice settings.

PLEASE SELECT ONE:

____ I certify that I am an APRN who has completed a minimum of two years of supervised prescriptive practice **OR** two years independent prescriptive practice and meet the requirements of 244 CMR 4.07 to engage in independent prescriptive practice.

____ I certify that I am an APRN who is supervised by a Qualified Healthcare Professional who has independent practice authority pursuant to 244 CMR 4.07, and have written guidelines for my prescriptive practice as required by 105 CMR 700003(C)(d) or

____ I certify I am a newly authorized APRN with less than two years supervised/independent prescriptive practice who will comply with the requirements of a supervising QHP and develop mutually agreed upon guidelines prior to prescribing.

____ I certify that I am a Certified Nurse Midwife.

____ I certify that I am a PA or CDTM Pharmacist, supervised by a physician, and have written guidelines for my prescriptive practice as required by 105 CMR 700003(C)(d).

____ I certify that I am a PA, who will comply with the requirements of a supervising physician and develop mutually agreed upon guidelines prior to prescribing.

I hereby certify that, under pains and penalties of perjury, all of the information submitted in this form is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this form is grounds for MCSR revocation or denial of the MCSR and may subject me to civil or criminal penalties.

Print Name: _____ Date: _____

Board License No._____

Signature: _____

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