Department of Public Health
Drug Control Program-Medication Administration Program
Waiver Request – OTC Method B Remote Verification

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)	DCF ☐ DDS ☐ DMH ☐ MRC ☐

MAP Policy for which waiver is requested:	MAP Policy 06-6, *Over-the-Counter Medications and Preparations*

A. Explain and document the undue hardship experienced at the MAP Registered site due to compliance with MAP Policy 06-06 (detail why the MAP Registered site is unable to accomplish in-person comparison of OTC label and HCP order by a licensed health care professional) and how implementation of the DPH MAP alternative procedures would alleviate that undue hardship. (May attach supplemental document(s), if pertinent):	
B. Explain and document the compensating features the DPH MAP Registered site will put into place if this waiver is granted:	A licensed healthcare professional will compare the manufacturer's label to the Health Care Provider order and verify the contents of the OTC medication or preparation via photos and phone communication or video communication with MAP Certified staff. MAP Certified staff must document the licensed health care professional verification encounter, including the name of the licensed health care professional. Pursuant to the licensed professional's comparison and verification, MAP Certified staff may: • initial the container; • place the name of individual and the date of verification on the container; and • document the verification on the HCP order by placing their initials and date of verification (in the margin) near the ordered medication The licensed healthcare professional will conduct a virtual training with the MAP Certified staff that is product specific and individual specific.

Service Provider Contact Information		
Name & 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