

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Office of Provider Engagement and Regulation Office of Controlled Substances Administration Kate Jackson, MPH, Director 4201 Patterson Avenue, 5th Floor Baltimore, MD 21215

Healthcare Practitioners Not Licensed in Maryland COVID-19-Related CDS Registration Waiver Form

INSTRUCTIONS

- In compliance with the <u>May 8, 2020 Notice: Waiver of CDS Registration Requirement</u>, out-of-state practitioners without a Maryland controlled dangerous substances (CDS) registration who are working with CDS at an authorized health care facility in Maryland, must complete and sign this Waiver Form.
- You may only use this waiver for practicing at the health care facility listed, which is licensed with both the Maryland Office of Controlled Substances Administration (OCSA) and the Drug Enforcement Agency (DEA). Practitioners working with CDS in any other setting are required to obtain a Maryland CDS registration.
- This waiver for registration is valid for the duration of the DEA waiver. Your Maryland CDS waiver and PDMP access will end at the time the DEA ends their waiver policy.
- Email completed Waiver Forms to Sandra Yankosky at <u>Sandra.yankosky@maryland.gov</u>
- With a signed waiver you may register for the Maryland PDMP using your home state DEA registration number. Contact the Maryland PDMP at https://crisphealth.org/services/prescription-drug-monitoring-program-pdmp/

HEALTH CARE FACILITY INFORMATION

Health Care Facility Name:		
Facility Address:		
City	State	Zip
Facility Contact Name (e.g. Credentialing Office):		
Facility Contact Phone Number:	Email:	

Facility need for practitioner: The health care facility finds that the below listed healthcare practitioner is needed to: (check all that apply)

Meet required staffing ratios

Ensure the continued and safe delivery of health care services

HEALTHCARE PRACTITIONER IDENTIFYING AND CONTACT INFORMATION

Full Name:		
Last	First	Middle
Mailing Address:		
City	State	Zip
Phone: Email:		
Profession:		
Out-of-state practitioner license:		
State of Licensure: Status of Licensure:	cense:	(active, restricted, etc)
Type of License:MD/DOPANP/N	MW DMD/DDS DPM C	Other:
License Number:	Expiration Date:	
Out-of-state DEA Number (must be issued for	r same state as out-of-state health	professional license):
State Issued for: DEA Number: _	Expiration	Date:
Status of DEA Registration:		
HEALTHCARI	E PRACTITIONER CERTIFICATION	
I declare and affirm under penalty of perjury t of my knowledge.		rue and complete to the best
Signature:		
Healthcare Practiti	oner	
HEALTHC	ARE FACILITY CERTIFICATION	
I declare and affirm under penalty of perjury t of my knowledge.	that the foregoing statements are t	rue and complete to the best
Signature:		
Facility Representa	ative	