



COMMONWEALTH OF VIRGINIA

Department of Health Professions

Prescription Monitoring Program

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REQUEST FOR A WAIVER OR AN EXEMPTION FROM REPORTING

Please provide the information requested below. (Print or Type) Use full name not initials

<u>Name of Dispenser</u>	<u>License or Permit Number</u>	<u>DEA Registration Number</u>
<u>Street Address</u>	<u>City</u>	
<u>State</u>	<u>Zip Code</u>	<u>Area Code and Telephone Number</u>
<u>Email Address: Point of Contact</u>	<u>Name of PIC (Pharmacy only)</u>	<u>Virginia License Number of PIC (Pharmacy only)</u>
Signature:	Date:	
Reason for approval of exemption/waiver request: (Check one box below)		
<input type="checkbox"/> Hardship created by a natural disaster or other emergency beyond the control of the permit holder. Please provide description:		
<input type="checkbox"/> Dispensing in a controlled research project approved by a regionally accredited institution of higher education or under the supervision of a governmental agency. Please attach a description of the research project.		
<input type="checkbox"/> This pharmacy or practitioner dispenses no Schedule II, III, IV or V controlled substances, naloxone, OR Drugs of Concern.		
<input type="checkbox"/> This pharmacy or practitioner is exempt from reporting according §54.1-2522 of the Code of Virginia. State exemption(s)		
<input type="checkbox"/> Other: Please provide description below or provide information as a separate attachment.		

For Department Use Only

Date Received:	<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved	Director or Designee Signature:	Date of Action:
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