

DISPENSER WAIVER / EXEMPTION FORM

Please provide the information requested below. (Print or Type) Use full name not initials. Also, **changes in pharmacy status** or Connecticut Department of Consumer Protection regulations may require pharmacies to resubmit a waiver / exemption form.

NAME OF DISPENSER

LICENSE OR PERMIT NUMBER

ADDRESS

CITY STATE ZIP

NAME OF PHARMACIST IN CHARGE (PHARMACY ONLY)

CT LICENSE NUMBER OF PHARMACIST IN CHARGE (PHARMACY ONLY)

TELEPHONE EMAIL ADDRESS

S I G N A T U R E

APPLICANT SIGNATURE

Date

REASON FOR WAIVER / EXEMPTION

(Check one box below)

Hardship created by a natural disaster or other emergency beyond the control of the permit holder.
 Please provide description:

This dispenser does not hold a Controlled Substance registration with Drug Enforcement Administration.

This dispenser does not dispense Schedule II, III, IV, and V controlled substances.

The dispenser is exempt from reporting according to Connecticut General Statute: Chapter 400j. State exemption(s)

Other: Please provide description below or provide information as a separate attachment.

Email form to dcp.pmp@ct.gov or fax to (860) 622-2608: State of Connecticut Department of Consumer Protection
Prescription Monitoring Program, 450 Columbus Blvd, Suite 901, Hartford, CT 06103, Telephone: (860) 713-6073

For Department Use Only

Date Received

Approved

Disapproved

Director or Designee Signature

Date of Action

