**Overdose Response Program (ORP)**

**Application for Entity Authorization**

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| **GENERAL INFORMATION** |
|  |
| Agency Name: |  |
| Address:City, State, Zip |  |
| Phone: |  | Fax: |  |
| Website: |  |
|  |  |
| Agency Director: |  |
| Email: |  |
|  |
| Training Director for ORP: |  |
| Address:City, State, Zip |  | Fax: |  |
| Email: |  | Phone: |  |

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|  **AGENCY TYPE**  |
| [ ] Public  | [ ] Private  | [ ]  Other |

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| **Is this the agency’s first application for authorization?** |
| [ ]  No | [ ]  Yes | If no, please indicate the date of your previous application **→** |  |
| **Briefly describe the agency’s mission:** |
|       |
| **Briefly describe your target training audience and anticipated approach to training:** |
|       |
| **Will a fee be charged to individuals for participating in the program?** | [ ]  No | [ ]  Yes |
| If you answered “Yes”, please specify the amount you will charge along with the justification for your fees. |
|       |
| **Will a fee be charged for replacing a lost certificate?** | [ ]  No | [ ]  Yes |
| If you answered “Yes”, please specify the amount. | $      |  |

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| **PRESCRIBING NALOXONE** |
| [ ]  No | [ ]  Yes | Will a licensed physician or advanced practice nurse be on site to write prescriptions for certificate holders? |
| **DISPENSING NALOXONE** |
| [ ]  No | [ ]  Yes | Will you dispense naloxone to certificate holders? If yes **→** **attach a copy of your entity’s dispensing protocol.** |
| [ ]  No | [ ]  Yes | Will you use a Standing Order for the dispensing of naloxone to certificate holders by entity employees or volunteers? If yes **→** **attach a copy of your entity’s standing order**. |
| [ ]  No | [ ]  Yes | Will you provide certificate holders with a pre-paid voucher to obtain naloxone from a partner pharmacy?  |
| [ ]  No | [ ]  Yes | Will you refer certificate holders to a local pharmacy to obtain naloxone through the Statewide Standing Order (in lieu of onsite dispensing)? |
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| **TRAINING PROGRAM MATERIALS** |
| An educational training program shall contain a core curriculum provided by the Department and may include any other relevant topic at the discretion of the authorized entity. |
| **Delivery format:** | [ ]  Classroom/Group | [ ]  One-on-one | [ ]  Outreach | [ ]  Video |
| [ ]  No | [ ]  Yes | Will your ORP training include topics and/or materials in addition to the Core Curriculum provided by DHMH? If yes, provide a brief description of the ancillary topic(s) in the space below AND attach copies of associated training materials. |
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| **RECORD MAINTENANCE AND REPORTING** |
| Please initial in the space provided your acknowledgement of the following: |
|  | Any change in information provided in this application will be submitted by this entity in writing to the Department within 30 days of the change, as required under COMAR 10.47.08.03D. |
|  | If this application for authorization is approved, the entity will maintain appropriate records and timely report all information to the Department as required under Maryland Health-General Article §13-3103 and COMAR 10.47.08.10 |

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| **SIGNATURE AND ATTESTATION** |
| Printed Name: |  |
| Title: |  |
| *I certify that the information provided in this application is complete and accurate to the best of my knowledge* |
| Signature: |  | Date: |

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| **PRACTITIONER INFORMATION** *The training must be conducted or supervised by a licensed physician, advanced practice nurse or pharmacist.* |
|  |
| Name: |  | Title: |
| Address:City, State, Zip |  | Email: |
| Phone: |  | Fax: |  |
| State License Number: |  | Expiration Date: |  |

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| **The Practitioner will:** Please indicate the practitioner’s role in training by selecting all that apply. |
| [ ]  Conduct Training | [ ]  Supervise other trainers If selected → | **attach a copy of your entity’s supervisory agreement** |
|  |  |
| **This practitioner’s license is active:** | [ ]  Yes[ ]  No – The practitioner may NOT conduct trainings or supervise trainers under and ORP |
|  |  |
| **This practitioner’s license has been suspended or revoked and reinstated within the past 5 years**:  | [ ]  No[ ]  Yes – Provide an explanation below |
|  |  |
| **There is an active investigation and/or pending disciplinary charges against this practitioner:** | [ ]  No[ ]  Yes – Provide an explanation below |

|  |  |
| --- | --- |
| **SIGNATURE**  |  |

|  |  |
| --- | --- |
| Practitioner signature: | Date: |

If there is more than 1 practitioner associated with your ORP, please duplicate the page and for inclusion in your re-application.

ORP Application Checklist/FAX Cover Page

TO: DHMH NALOXONE

 410-402-8601

FROM:

DATE:

# Pages:

 (including cover)

Checklist

|  |  |  |  |
| --- | --- | --- | --- |
| Yes | No | N/A | Application Requirement |
|  |  |  | ORP Application is complete with signature and date |
|  |  |  | The Practitioner Information is complete with practitioner’s signature |
|  |  |  | Described the mission/vision of the organization |
|  |  |  | Indicated and justified any fees that will be charged by the program |
|  |  |  | Supervisory agreement, if applicable, is attached |
|  |  |  | A copy of the Standing Order, if applicable, is attached  |
|  |  |  | A copy of the Dispensing Protocol, if applicable, is attached  |
|  |  |  | Any additional proposed training materials are attached for review by DHMH |