Attachment B/C

Maryland Nurse Dispensing Program
Request to Add Medication/Device to Formulary
For Registered Nurse Dispensing

Name of Local Health Department:_____

To request approval for the addition of a drug or device, provide the following information:

Name of Drug or Device:_____

Name of Vendor or Manufacturer:_____

Dosage Strength:_____

Use (specified, recommended or suggested)

_____

_____

_____

For use in the following clinic(s):

- ☐ Alcohol and Drug Abuse Clinic
- ☐ Communicable Disease Clinic
- ☐ Family Planning/Reproductive Health Clinic

Requestor's name:_____Title: _____

Phone: _____ Email: _____

_____

Signature of Authorized Physician/ Medication Director Date

_____

Signature of Health Officer Date

Return form to: Ms. Ginny Seyler
Infectious Disease and Environmental Health Administration
201 W. Preston St.
Baltimore, MD 21201
seylerv@dhmh.state.md.us