

**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:

Sadie Peters MA, MD, MHS
Physician Advisor
Maryland Department of Health
Maternal & Child Health Bureau
201 W. Preston Street
Baltimore MD 21201
sadie.peters@maryland.gov