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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-02788 (04/2021) | **STATE OF WISCONSIN**Page 1 of 2 |
| **CERTIFIED NARCOTIC TREATMENT SERVICE FOR OPIATE ADDICTION:****MEDICATION UNIT APPLICATION** |
| * Questions regarding this form may be directed to the Division of Quality Assurance (DQA), Behavioral Health Certification Section (BHCS) at 608-261-0656.
* Return completed form and required fee to: DHS DQA - Behavioral Health Certification Section / PO Box 2969 / Madison, WI 53701-2969. The fee for each medication unit is $500.
* After the completed application and fee is received a BHCS surveyor will contact you to arrange a date and time for an onsite survey.
* Medication unit means a facility established as part of a service but geographically separate from the service, from which licensed private practitioners and community pharmacists are:
	1. Permitted to administer and dispense a narcotic drug.
	2. Authorized to conduct biochemical monitoring for narcotic drugs.
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| GENERAL INFORMATION: MAIN CLINIC |
| MAIN CLINIC INFORMATION |
| Name – Main Clinic | Certification Number |
|       |       |
| Phone Number | Fax Number | Email Address (Contact Person) |
|       |       |       |
| Street Address | City | County | State | Zip Code |
|       |       |       |    |       |
| MEDICATION UNIT INFORMATION |
| If applying for certification for multiple medication unit locations, submit a separate application and fee for each one |
| Medication Unit Information |
| Name – Medication Unit | Phone Number |
|  |       |
| Street Address | City | State | Zip Code |
|       |       |    |       |
| Distance from Main Office:       milesTotal number of patients to be served by the primary facility and medication unit:       patientsTotal number of patients that will be served only at this medication unit:       patients |
| Required Supporting Documentation *(submit these required documents specific to this medication unit)* |
| [ ]  Schedule indicating days and hours when this medication unit office is open[ ]  Documentation describing how consumer records are stored[ ]  Description of the policies of oversight for the clinic administrator and of the policies for collaboration and/or supervision in the medication unit[ ]  Copy of the SMA-162 form that was submitted to SAMHSA adding a medication unit[ ]  Description of how the medication unit receives the medication supply[ ]  Diagram and description of the facilities to be used as a medication unit[ ]  Justification for need to establishing a medication unit |
| Attestation |
| Check to confirm agreement with each attestation statement and sign in the section below.[ ]  I attest that the medication unit is limited to administering and dispensing the narcotic treatment drug and collecting samples for drug testing or analysis[ ]  I attest that the sponsor agrees to retain responsibility for patient care[ ]  I attest that all statements made on this form are true and correct to the best of my knowledge. |
| **SIGNATURE** – Entity Owner, Representative, or Authorized Representative | Date Signed |
|  |  |
| Full Name *(Print or type)* | Title |
|       |       |

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| QUALIFIED STAFF ROSTER – MEDICATION UNIT |
| * If applying for certification for multiple medication units, submit a separate application for each unit
* **NOTE:** Pursuant to Wis. Stat. § 50.065(1), “caregiver” means (1) a person who is, or is expected to be, an employee or contractor of an entity; (2) who is, or is expected to be, under the control of an entity, as defined by the department by rule; and (3) who has, or is expected to have, regular and direct contact with clients of the entity.
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| **Name** | **Position Title**(e.g., Clinical Administrator) | **Professional Credential**(e.g., LCSW) | **DSPS License Number**(if applicable) | **Hours Per Week at This Med Unit** |
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