MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF NARCOTICS AND DANGEROUS DRUGS

APPLICATION FOR WAIVER FROM ELECTRONIC PRESCRIBING

LAST NAME:

FIRST NAME:

BNDD REGISTRATION NUMBER:

EMAIL ADDRESS:

PROFESSIONAL LICENSE TYPE:

☐ MD ☐ DO ☐ DDS ☐ DMD ☐ APRN ☐ OD ☐ PA ☐ DPM ☐ Asst. Physician

CHECK BOX(ES) TO IDENTIFY THE REASON FOR THE WAIVER

☐ Economic Hardship

☐ Technological Limitations

☐ Other exceptional circumstances

Additional details in support of waiver request:

CERTIFICATION AND SIGNATURE

The undersigned hereby certifies that the information provided herein is true and accurate.

Registrant Signature (typed electronic signature) Date

THIS FORM MUST BE EMAILED TO THE BNDD AT BNDDRxWAIVER@health.mo.gov. THE BNDD WILL PROCESS APPLICATIONS IN THE ORDER IN WHICH THEY ARE RECEIVED. A WRITTEN NOTIFICATION OF WAIVER WILL BE SENT BY THE BNDD TO THE EMAIL ADDRESS PROVIDED ABOVE.