Newfoundland & Labrador Pharmacy Board

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Application for Authorization to Participate in Opioid Agonist Maintenance Treatment

Full Name:

Last Name _____ First Name & Middle Initial _____ Registration # _____

Contact Information:

Email Address _____ Phone Number _____

Employment Information:

Name of Primary Place of Employment _____

Street Address _____ P.O. Box (if applicable) _____

City/Town _____ Postal Code _____

Certifications:

By signing below, I certify that:

- The information contained in this application is complete and correct and I recognize that providing false or incomplete information on the application may be cause for revocation of authorization or an allegation of conduct deserving of sanction.
- I have reviewed the *Standards for the Safe and Effective Provision of Opioid Agonist Maintenance Treatment* and will abide by the standards, limits and conditions that apply to the provision of opioid agonist maintenance treatment and restrict my practice to those areas in which I am competent.
- I have attached proof of successful completion of the required opioid agonist maintenance treatment orientation program, as approved by the board.

Applicant's Signature _____ Date Signed _____

Registrants are reminded that authorization is not effective until they have received notification from NLPB that the application has been approved.