

MARYLAND BOARD OF PHYSICIANS  
P.O. Box 2571  
Baltimore, Maryland 21215  
*www.mbp.state.md.us*  
*E-mail: mdh.mbpADispense@maryland.gov*

**APPLICATION: ADDENDUM FOR PHYSICIAN ASSISTANT (PA)  
ADVANCED DUTY TO DISPENSE PRESCRIPTION DRUGS  
INSTRUCTIONS AND IMPORTANT INFORMATION**

Before completing this application, a PA must have (1) practiced under a Board-approved delegation agreement with a primary supervising physician (PSP) for at least 90 days; (2) operated for one year under a delegation agreement that grants the PA prescriptive authority; and (3) dispensed prescription drugs in training in at least 25 instances under the direct, in-person supervision of the PSP. The required procedure log to be completed is attached to this application.

Please review the Frequently Asked Questions (FAQs) on the Board of Physicians' (the Board's) Website. The FAQs may assist you in preparing to demonstrate to the PSP a basic knowledge of statutes and regulations governing the practice of dispensing prescription drugs.

*For the Board's dispensing regulations, COMAR 10.32.23 effective March 26, 2018, visit the Board's Website at:  
[https://www.mbp.state.md.us/resource\\_information/res\\_prof/resource\\_Practitioner\\_regs.aspx](https://www.mbp.state.md.us/resource_information/res_prof/resource_Practitioner_regs.aspx)*

Questions regarding this application or PA drug dispensing may be e-mailed to: *mdh.mbpADispense@maryland.gov*.

**Completing the Application**

1. Complete Part 1, including your e-mail address for Board correspondence regarding this dispensing permit. Also include the e-mail address of your primary supervising physician (PSP) so that your PSP can be copied. Please make sure that all of your addresses with the Board are up to date, as required by Maryland law (Health Occupations Article, §14-316). For qualification questions 1 through 5, answer "yes" or "no." If you answer "yes" to any of the qualification questions, you are ineligible for an advanced duty to dispense prescription drugs. Do not proceed with the application if you are ineligible.
2. Complete Part 2 regarding your core duty delegation agreement and (if applicable) your Maryland CDS registration.
3. Complete Part 3 to explain why delegation of the dispensing of prescription drugs to you would be in the public interest.
4. Complete Part 4 regarding the locations where you intend to dispense prescription drugs. The locations listed must be locations where your PSP named in this application is authorized to dispense.
5. Complete all character and fitness questions in Part 5. If you answer "YES" to any question, on a separate sheet of paper, please provide a signed and dated detailed explanation and attach any supporting documents. Failure to provide documentation and a signed and dated explanation will delay the processing of your application.
6. Complete the additional questions in Part 6.
7. Complete the attestations in Part 7 and attach the required procedure log.
8. Complete the survey questions in Part 8 to assist the Board and OCSA in fulfilling their responsibilities under Maryland law. Answers provided to these questions will not affect your eligibility for an advanced duty to dispense prescription drugs.
9. Complete Part 9 by signing and dating your application. Your PSP also must sign and date this application. Please keep a copy of your application.

**NOTE**

*The primary supervising physician (PSP) named in this application must have an active Maryland license and an active Maryland permit to dispense prescription drugs.*

PA DISPENSING  
ADVANCED DUTY  
APPLICATION  
10/2018

MARYLAND BOARD OF PHYSICIANS  
P.O. Box 2571; Baltimore, Maryland 21215  
E-mail: [mdh.mbpPAdispense@maryland.gov](mailto:mdh.mbpPAdispense@maryland.gov)

APPLICATION  
ADDENDUM FOR PHYSICIAN ASSISTANT (PA)  
ADVANCED DUTY TO DISPENSE PRESCRIPTION DRUGS

**Part 1** Complete Part 1. The Board will use this information to contact you regarding this application. Complete all qualification questions to determine if you meet the requirements for approval of the advanced duty to dispense prescription drugs.

PA Name: \_\_\_\_\_  
Last First Middle/Maiden

PA License Number: \_\_\_\_\_

Primary Supervising Physician Name: \_\_\_\_\_  
Last First Middle/Maiden

Primary Supervising Physician License Number and Dispensing Permit Number: \_\_\_\_\_ / \_\_\_\_\_  
(Note: Both the license and permit must be in "active" status) License Permit

**PAs: For Correspondence**

Please provide your e-mail address and the e-mail address of your primary supervising physician (PSP) below. All Board correspondence regarding this application for an advanced duty to dispense prescription drugs will be sent to this address. All other correspondence will continue to be mailed to your official address of record with the Board. \*\*

PA's E-mail Address: \_\_\_\_\_

PSP's E-mail Address: \_\_\_\_\_

**\*\* Reminder:** To change your official address of record with the Board, go to the Board's Website: [www.mbp.state.md.us](http://www.mbp.state.md.us). Under "Licensure" on the homepage, click on the option "Update your Profile."

Qualification Questions

1. \_\_\_ Yes \_\_\_ No Is your PA license currently suspended by any order imposed by any medical or PA licensing board?
2. \_\_\_ Yes \_\_\_ No Is your PA license currently on probation by any order imposed by any medical or PA licensing board?
3. \_\_\_ Yes \_\_\_ No Is your PA license currently subject to any restrictions or conditions on your license related to the abuse, misuse, or improper prescribing of drugs by any order imposed by any medical or PA licensing board?
4. \_\_\_ Yes \_\_\_ No Within the last five years, has your PA license been sanctioned by any medical or PA licensing board for the commission of a crime of moral turpitude, or sanctioned for a violation of Health Occupations Article, §§15-314(a)(7), (8), (9), (10), or (28), Annotated Code of Maryland, or a similar statute of another state?
5. \_\_\_ Yes \_\_\_ No Within the last five years, have you had your CDS registration issued by the Office of Controlled Substances Administration or its predecessor or the registration issued by the federal Drug Enforcement Administration:
  - a. Revoked;
  - b. Suspended; or
  - c. Voluntarily relinquished or surrendered while under investigation or after being informed that an investigation will be commenced?

**If you answered "yes" to any of the five qualification questions, you do not meet the qualifications for the advanced duty of dispensing prescription drugs.**

**Part 2** Complete Part 2. Note that a PA can dispense only the type of drugs that the Board has approved the PA to prescribe through approval of prescriptive authority.

Date of approval of your core duty delegation agreement with the primary supervising physician named on Page 1: \_\_\_\_\_

Date that prescriptive authority was granted or approved: \_\_\_\_\_

Requesting approval to dispense (check one): \_\_\_\_\_ Non-CDS Prescription Drugs \_\_\_\_\_ CDS Prescription Drugs \_\_\_\_\_ Both

Your Maryland CDS registration number (if applicable): \_\_\_\_\_ CDS registration expiration date: \_\_\_\_\_

**Part 3** "In the public interest" as defined in Health Occupations Article §12-102(a)(2) means "the dispensing of drugs or devices by a licensed [physician] to a patient when a pharmacy is not conveniently available to the patient." Explain below why the delegation of the dispensing of prescription drugs to you would be in the public interest.

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**Part 4** Complete Part 4. If you are going to dispense from a single location only, skip Item B. If you need more room to list additional addresses, please attach a separate sheet signed and dated by you and your primary supervising physician.

**A. Main address where you will dispense prescription drugs:**

Name of Facility or Practice:				
Street Address:				
City:	State:	Zip Code:	Telephone Number:	

**B. Additional address(es)\* where you will dispense prescription drugs:**

_____	_____	_____	_____	_____
Facility Name and Street Address	City	State	Zip Code	Telephone Number
_____	_____	_____	_____	_____
Facility Name and Street Address	City	State	Zip Code	Telephone Number

*\*List only additional addresses where your primary supervising physician (PSP) listed on Page 1 of this application is authorized to dispense.*

*Please keep a copy of your application.*

**Part 5** Complete the character and fitness questions ("a" through "k") by checking either YES or NO. For YES answers, you must provide a written explanation (signed and dated by you). See the instructions at the bottom of this page.

**YES**    **NO**    *Since you last submitted an application for your PA license (initial, renewal, or reinstatement) to the Board:*

- a.   Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, denied your application for licensure, reinstatement, or renewal **OR** taken action against your license? Such actions include, but are not limited to, limitations of practice, required education, admonishment or reprimand, suspension, probation or revocation.
- b.   Has any licensing or disciplinary board in any jurisdiction (including Maryland), or a comparable body in the armed services or the Veterans Administration, filed any complaints or charges against you or investigated you for any reason?
- c.   Have you withdrawn your application for a PA license or other health professional license?
- d.   Has a hospital, related health care institution, HMO, or alternative health care system investigated you or brought charges against you?
- e.   Has a hospital, related health care institution, HMO, or alternative health care system denied your application; failed to renew your privileges; or limited, restricted, suspended, or revoked your privileges in any way?
- f.   Have you committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or *nolo contendere*, or for which you were convicted or received probation before judgment? Such offenses include, but are not limited to, driving while under the influence of alcohol or controlled dangerous substances.
- g.   Have you ever pled guilty or *nolo contendere* to any criminal charge; are there any charges pending against you in any court of law; are you currently under arrest or released pending trial; or is there an outstanding warrant for your arrest?
- h.   Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a physical, mental, emotional, or nervous disorder or condition) that in any way affects your ability to practice your profession in a safe, competent, ethical, and professional manner?
- i.   Has your employment or contractual relationship with any hospital, HMO, other health care facility, health care provider, institution, armed services, or the Veterans Administration been terminated for disciplinary reasons?
- j.   Have you voluntarily resigned or terminated a contract with any hospital, HMO, other health care facility, health care provider, institution, armed services or the Veterans Administration while under investigation by that institution for disciplinary reasons?
- k.   Have you surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction, any entity of the armed services or the Veterans Administration?

*If you answered YES to any question above, on a separate sheet of paper, provide a signed and dated detailed explanation and attach any supporting documents. Failure to provide documentation and a signed and dated explanation will delay the processing of your application.*

**Part 6** Carefully read the following questions and check "Yes" or "No" for each. Operating a dispensary in a manner contrary to your answers below may be grounds for disapproval of your dispensing advanced duty and/or sanctions on your PA license.

**Additional Questions**

1. \_\_\_ Yes \_\_\_ No Do you agree to dispense medications only to those patients who state that no pharmacy is conveniently available to them?
2. \_\_\_ Yes \_\_\_ No Do you understand that you are responsible for being familiar with all laws and regulations that govern the dispensing of prescription drugs in Maryland, including Health Occupations Article, §§12-102, 12-403, 12-505, and 12-604; Maryland Department of Health regulations at COMAR 10.13.01, 10.19.03.04, 10.19.03.05, and 10.19.03.07; and Maryland Board of Physicians regulations at COMAR 10.32.23?
3. \_\_\_ Yes \_\_\_ No Do you agree to comply with the above statutes and regulations?
4. \_\_\_ Yes \_\_\_ No Do you understand that you are responsible for being familiar with Federal laws and regulations governing dispensing of prescription drugs, including dispensing of controlled dangerous substances?
5. \_\_\_ Yes \_\_\_ No Do you agree to comply with those Federal statutes and regulations?
6. \_\_\_ Yes \_\_\_ No Do you understand that the failure to comply with Federal and Maryland statutes and regulations on dispensing may result in sanctions on your PA license?
7. \_\_\_ Yes \_\_\_ No Do you understand that Maryland law requires you to report any change of address to the Board?
8. \_\_\_ Yes \_\_\_ No Do you understand that you must personally prepare and dispense any drugs from your dispensary, and that you may not delegate any part of the dispensing process?
9. \_\_\_ Yes \_\_\_ No Do you understand that you must be physically present and must personally perform the final check before a drug is dispensed?
10. \_\_\_ Yes \_\_\_ No Is there a plan in place to handle drug recalls, including notifications to patients, at each dispensing location?
11. \_\_\_ Yes \_\_\_ No Do you understand that the Office of Controlled Substances Administration can enter and inspect a dispensing facility at all reasonable hours, and that you, your primary supervising physician (PSP), or your PSP's designated representative must be available at all times to sign an acknowledgement that the inspection took place?
12. \_\_\_ Yes \_\_\_ No Do you understand that, if granted the advanced duty of dispensing, you may dispense drugs only for prescriptions written by yourself (not other PAs) or by your primary supervising physician listed on this application?

**Part 7** Complete the attestations below. Answer "Yes" or "No" to all items, and attach the procedure log referenced in the last statement below.

I understand that the following items are requirements before this advanced duty may be approved, and I hereby attest that I have met those requirements as follows:

- \_\_\_ Yes \_\_\_ No The physician named on Page 1 of this application has supervised me as my primary supervising physician under an approved delegation agreement for at least 90 days.
- \_\_\_ Yes \_\_\_ No I have been delegated prescriptive authority pursuant to a Board-approved delegation agreement for at least one year.
- \_\_\_ Yes \_\_\_ No The procedure log attached to this application accurately represents at least 25 training instances during which I have dispensed medications under the direct in-person supervision of my primary supervising physician.

**Part 8**

Read the following survey questions and answer to the best of your ability. Your answers will not be used in determining whether to approve or disapprove the advanced duty to dispense prescription drugs but the statistical information collected will help the Board and the Office of Controlled Substances Administration in fulfilling their responsibilities under Maryland law.

Survey Questions

1. Do you intend to:  
 Yes  No      Dispense medications for chronic pain?  
 Yes  No      Treat 35% or more of your patients for injuries covered by Workers' Compensation Insurance?  
 Yes  No      Treat 35% or more of your patients for weight issues?
2.  Yes  No      Is your primary location of practice at an urgent care center?
3.  Yes  No      Do you intend to dispense controlled dangerous substances?
4.  Yes  No      Do you regularly prescribe Schedule II drugs for any chronic condition, including addiction?
5.  Yes  No      Are you required to dispense as a condition of employment?
6.  Yes  No      Will you make the final decision concerning which medications will be purchased by and dispensed from the dispensary at your place of work? If you don't know, check "No."
7.  Yes  No      Will you make the final decision concerning which pharmacies, manufacturers, or distributors supply medications to the dispensary at your place of work? If you don't know, check "No."
8.  Yes  No      Do you (or do you intend to) bill in your own name for drugs that you dispense?
9.  Yes  No      Have you had any formal training or education in the dispensing of medications?

**Part 9**

Both the PA and the primary supervising physician must personally sign and date the certifications below.

I hereby certify that I have personally completed this application for advanced duties, that the information I have given is true and accurate to the best of my knowledge, and that I understand that I am responsible for complying with all statutes and regulations regarding dispensing.

\_\_\_\_\_  
Printed name of PA

\_\_\_\_\_  
Signature of PA

\_\_\_\_\_  
Date

I hereby certify that I have personally reviewed this application, that the information given is correct to the best of my knowledge, that I am the primary supervising physician of the PA on whose behalf this application is filed and that I possess an active dispensing permit issued by the Maryland State Board of Physicians (Board).

\_\_\_\_\_  
Printed name of Primary Supervising Physician

\_\_\_\_\_  
Signature of Primary Supervising Physician

\_\_\_\_\_  
Date



