

**NH Bureau of Developmental Services**  
**Request for Waiver to He-M 1201**

<b>Responsible Area Agency</b> (check one) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <b>Date:</b> _____
Request is for an <b>Initial</b> <input type="checkbox"/> or <b>Renewal</b> <input type="checkbox"/> waiver?
<b>Provider agency name and address (if applicable):</b>
<b>Residence or Day Service name and address:</b>
Indicate specific section of <b>He-M 1201</b> for which a waiver is being sought: <b>He-M 1201.</b>
Provide an explanation of why a waiver to this standard is sought:
What alternative is proposed to satisfy regulatory intent?
Number of staff/providers authorized to administer medications: _____ Nurse Trainer phone # _____ Number of people receiving medication within certified service: _____
I certify that policies and procedures are in place for: <ul style="list-style-type: none"><li>• Nurse Trainer oversight of authorized staff</li><li>• Communication protocols between Day and Residential Services</li></ul>
Nurse Trainer signature: _____ Date: _____
Individual/Guardian (if applicable) signature: _____ Date: _____
AA Executive Director or designee signature: _____ Date: _____
Medication Committee: Approved <input type="checkbox"/> Denied <input type="checkbox"/>
Waiver will be effective from _____ until _____ ( <i>duration not to exceed 5 years</i> )
Medication Committee Chair signature: _____ Date: _____

**Submit completed request to:**  
BDS  
ATTN: Medication Committee  
State Office Park South  
105 Pleasant St - Main Building  
Concord, NH 03301