**INLAND COUNTIES EMERGENCY MEDICAL AGENCY**
***Serving San Bernardino, Inyo and Mono Counties***
**1425 SOUTH "D" STREET**
**SAN BERNARDINO, CA 92415-0060**
**(909) 388-5823 FAX: (909) 388-5825**

# DRUG AND EQUIPMENT WAIVER REQUEST FORM

Date: _____

Provider Name: _____

Requested By: _____
*Name, Title (Please Print)*

Name of Medication or Equipment: _____

Concentration (mg/ml): _____

Attempted to locate approved equip. or meds from other sources: ☐ Yes ☐ No

Substitution Request (Alt. equipment/packaging, concentration, or amount): ☐ Yes ☐ No ☐ N/A

Requested Substitution: _____

Concentration (mg/ml): _____

Training provided for substitution: ☐ Yes ☐ No ☐ N/A

**You are advised that your agency and ordering medical director is solely responsible for full compliance with all local, state, and federal regulations governing purchase, distribution, storage and administration of all medications including controlled substances. Any loss or diversion of such substances must be immediately reported to ICEMA and appropriate state or federal agencies. The provider agency must provide adequate education to staff to prevent potential medication errors and document the completion of this education on an approved ICEMA Education Roster.**

**Provider must notify ICEMA immediately if the shortage or substitution adversely impacts the care of any patient.**

**ICEMA USE ONLY**

Date Received: _____ Waiver Requirements Verified: ☐ Yes ☐ No

Waiver Granted: ☐ Yes ☐ No Waiver Length: ☐ 30 Days.

Date Granted: _____ Approved by: _____