Arizona Medical Board
1740 W. Adams Street, Suite 4000
Phoenix, AZ 85007
Phone: (480) 551-2700 Fax: (480) 551-2702
Website: www.azmd.gov

DATA Waiver Eligibility Fact Sheet

Effective August 27, 2019, the Board will begin accepting the DATA Waiver Eligibility application pursuant to the Drug Addiction Treatment Act of 2000 (DATA Waiver Eligibility) to practice opioid use disorder treatment in an outpatient facility.

A completed application must be submitted in PDF format to Michelle.Robles@azmd.gov.
The application must not be more than 10 pages.

Board Staff will review the application for completeness and place it on the Board's agenda for review and action. A public meeting notice letter will be sent to the address on the application informing the applicant of date and time of review by the Board. Please be aware that an incomplete application will be considered deficient and will not move forward for review by the Board until all required information is received.

If approved by the Board, the training facility shall submit a list in Excel format with the name and address of all recipients of the training indicating they've met the requirements of the Board approved curriculum/training and that they are DATA Waiver Eligible. Upon receipt of the list of names the Board will issue a written notice to each qualified physician.

Example of Excel format:

Full Name (First and Last Name)	Street Address	Suite, Floor, Apt #	City	State	Zip

Upon receipt of the full DEA license, a physician with an approval letter for DATA waiver from the Board may submit the Board letter to SAMHSA for approval at http://buprenorphine.samhsa.gov/forms/select-practitioner-type.php.

If the initial application is denied, the Board will send written notice informing applicant of the action. There may be a single appeal for reconsideration of the waiver application.

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DATA Waiver Eligibility Application

Name of Institution, School or Individual:

First Name: **Last Name:**

Mailing Address:

City: **State:** **Zip Code:**

Email Address:

Number of Individuals receiving training or education:

Brief description of training or experience:

Please include supporting documentation that shows that the training or experience addresses the following *(please note: application must not be more than 10 pages long)*:

a. Opioid maintenance and detoxification
b. Appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder
c. Initial and periodic patient assessments (including substance use monitoring)
d. Individualized treatment planning, overdose reversal, and relapse prevention
e. Counseling and recovery support services
f. Staffing roles and considerations
g. Diversion control

Please check a box:

☐ *I hereby certify I am an authorized individual to sign and submit this waiver application.*

☐ *I hereby certify I am authorized to sign and submit this waiver application on behalf of the above named facility.*

Signature: **Date:**