MCA Application to Adopt Naloxone Leave Behind
Optional Protocol

Requesting MCA: _____

Date of Request: _____

Anticipated Implementation Date: _____

Type of Cognitive Training:

☐MI-Train

☐In-person (if desired, lesson plan will be provided)

Participating Agency Information:

Agency Name*	**Competency Verification Date**	**Last Date of 3.4 Submission****

*Additional agencies can be attached.
**Data compliance is mandatory for approval.

Participating Pharmacy Information:

Pharmacy (hospital) Name*

*Additional agencies can be attached.

MCA Representative Name (if applicable): _____

MCA Representative Signature (if applicable): _____

MCA Medical Director Name: _____

MCA Medical Director Signature: _____