Naloxone Agency Request Form

I am a representative of an agency that responds to emergencies involving individuals who may be at risk of experiencing an opioid-related overdose or to emergencies that may place the first responder at risk for exposure to opioids.

Agency Name: _____

Write in the box below the facts that support the statement above (this information will be kept confidential, but is required to verify your need for Naloxone):

☐ I have received information on recognizing and responding to a possible opioid overdose.

☐ I have received basic instructions on how to administer Naloxone.

☐ I will ensure all persons within my agency who access and/or administer Naloxone have watched the training video prior to administering Naloxone.

Signature: _____ Date Signed: _____

Print Name: _____ Date of Birth: _____

Law Enforcement Agency Information Form
Naloxone (Narcan©) Nasal Spray Distribution

NUMBER OF KITS REQUESTED: _____

AGENCY POINT OF CONTACT: _____

AGENCY POINT OF CONTACT EMAIL ADDRESS: _____

AGENCY NAME: _____

AGENCY STREET ADDRESS (No P.O. BOX): _____

CITY: _____ ZIP: _____ COUNTY: _____

CONTACT PHONE NUMBER: _____

Important Information on Replacement Kits:

It is important that your agency establishes a point of contact who will be responsible for completing all necessary forms to obtain naloxone. Agency request forms must be returned to narcanadmh@mh.alabama.gov.

Once your request is approved, you will be contacted to schedule pick up or arranged delivery. If your agency is located within 80 miles of Montgomery, pick up will **ONLY** be on Tuesdays, 11-:00 am to 3:00 pm. Pick up will be at 1635 Mitchell Young Rd, MGM, AL 36108. Agencies outside of an 80 mile radius of Montgomery will receive their kits FedEx.

Expired kits should be reported to opioidcrisis@adph.state.al.us.

As kits are administered, the point of contact for your agency is responsible for sending the information listed below. Information should be sent to opiodcrisis@adph.state.al.us.

- Date/Time used
- Age/Race of recipient
- Nonfatal or Fatal results
- Number of doses administered
- Name and phone number of point of contact requesting the replacement.

Replacement kits will not be approved unless the required information is received.

By signing below, you are agreeing to comply to the terms in the box above.

Signature: _____ Date Signed: _____

Print Name: _____ Date of Birth: _____