State of Illinois
Department of Human Services - Division of Alcoholism and Substance Abuse

DRUG OVERDOSE PREVENTION PROGRAM ENROLLMENT FORM

Agency Name: _____ Date: _____

Address: _____

Suite, Floor, Room, P.O. Box No.: _____

City: _____ State: _____ Zip Code: _____

County: _____

Authorized Provider Information:
Health Care Facility/Professional (Check all that apply)

- ☐ DASA Drug Treatment Program
- ☐ License Prescription Practitioner
- ☐ Hospital
- ☐ For Profit Community-Based Organization
- ☐ Not-for-Profit Community-Based Organization
- ☐ Local Health Department
- ☐ Urgent Care Facility
- ☐ Other _____

Program Director's Name: _____

Program Director's Name: _____

Address: _____

Suite, Floor, Room, P.O. Box No.: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

E-Mail Address: _____

Health Care Professional (HCP) Name: _____

Address: _____

Suite, Floor, Room, P.O. Box No.: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

E-Mail Address: _____

License Type (Check One)

☐ Physician ☐ Physician Assistant ☐ Advanced Practice Nurse

Department of Financial and Professional Regulation License Number: _____

Brief Description of Targeted Population

Targeted Responder Outreach/Recruitment Strategy

How or what process would the agency use to inform the community about the Drug Overdose Prevention Program?

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I have reviewed the Public Act (096-0361 (20 ILCS 301/5-23 new), DHS/DASA policies and procedures.

Program Director's Signature _____ Date _____

Program Director's Printed Name _____ Date _____

Affiliated Prescriber(s):

Name: _____

License Type (Check One)

☐ Physician ☐ Physician Assistant ☐ Advanced Practice Nurse

Department of Financial and Professional Regulation License Number: _____

Name: _____

License Type (Check One)

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Department of Human Services - Division of Alcoholism and Substance Abuse

DRUG OVERDOSE PREVENTION PROGRAM ENROLLMENT FORM

Opioid Overdose Prevention Program Sites: (Provide name of agency/facility/office and address.)

Agency Name: _____

Address: _____

Suite, Floor, Room, P.O. Box No.: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ County: _____

Agency Name: _____

Address: _____

Suite, Floor, Room, P.O. Box No.: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ County: _____

Agency Name: _____

Address: _____

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City: _____ State: _____ Zip Code: _____

Telephone Number: _____ County: _____

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