


MACS

Maryland Addiction Consultation Service
www.marylandMACS.org
1-855-337-MACS (6227)

MACS Sign-Up Form

Please complete a separate form for each interested prescriber

Today's Date:

Prescriber Name:	
Primary Practice Name (if applicable):	
Primary Practice Address:	
Phone:	Fax:
Would you like to receive text messages from MACS at this phone number?	<input type="checkbox"/> I would like to receive text messages and agree to the Terms of Service and Privacy Policy 5 Msgs/Month. Msg & Data
Email:	Best way to contact me:
Prescriber Type: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PA <input type="checkbox"/> NP <input type="checkbox"/> CNM <input type="checkbox"/> CNP <input type="checkbox"/> CRNA <input type="checkbox"/> PharmD <input type="checkbox"/> Other: _____	
Years in Practice:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Prefer to self-describe: _____
Do you consider yourself Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What do you consider to be your racial identify? <input type="checkbox"/> Alaska Native American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Prefer to self-describe: _____	
Type of Practice: <input type="checkbox"/> Solo or Private Practice <input type="checkbox"/> Academic Medical Center <input type="checkbox"/> Federally Qualified Health Center (FQHC) <input type="checkbox"/> Addiction treatment program <input type="checkbox"/> Public Health Department <input type="checkbox"/> Community Mental Health Center <input type="checkbox"/> Pain management <input type="checkbox"/> Other: _____	Type of Specialty: <input type="checkbox"/> Family Medicine <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Addiction Medicine <input type="checkbox"/> Emergency Medicine <input type="checkbox"/> Psychiatry <input type="checkbox"/> Pediatrics <input type="checkbox"/> Pain medicine <input type="checkbox"/> Obstetrics/Gynecology <input type="checkbox"/> Other: _____
Do you have your Buprenorphine Waiver? <input type="checkbox"/> Yes <input type="checkbox"/> In Process <input type="checkbox"/> No  If yes: How many patients are you waivered to treat ? <input type="checkbox"/> 30 patients <input type="checkbox"/> 100 patients <input type="checkbox"/> 275 patients How many patients are you currently treating with buprenorphine ? _____ patients Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	How did you hear about MACS? <input type="checkbox"/> Presentation at my practice <input type="checkbox"/> Drop-in visit to my practice <input type="checkbox"/> MACS training or presentation <input type="checkbox"/> Web Search <input type="checkbox"/> College/Professional Network <input type="checkbox"/> Conference/Professional meeting <input type="checkbox"/> Mailing <input type="checkbox"/> Email <input type="checkbox"/> Social Media <input type="checkbox"/> Other: _____
Have you ever had formal addiction training in addition to your buprenorphine waiver training? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:	

MACS is a grant-funded program sponsored by the Maryland Department of Health. Therefore, the names of participating prescribers as well as information collected by MACS may be shared with state officials as requested. MACS provides de-identified, consultations for prescribers about their patients and does not assume liability for any direct patient care. Prescribers who sign up for MACS will be informed about upcoming training opportunities.

Please send forms to: (Fax) 1-855-337-6227; (Email) tsommer@som.umaryland.edu