



Maryland Prescription Drug Monitoring Program

This will certify that I, \_\_\_\_\_ (please type name) have viewed the Maryland Prescription Drug Monitoring Program Video (found at: <https://www.youtube.com/watch?v=VRQsZ9bxvoY&t=136s>) on \_\_\_\_\_ (please provide MM/DD/YY). I understand the information that was provided in the Video and agree to adhere to the prescribing practices outlined.

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Signature and Date