



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.

Signature and Date