Naloxone Distribution Program (NDP) Attestation

Organization Name: _____

Name of Primary Contact: _____

Title of Primary Contact: _____

Email of Primary Contact: _____

As the _____ of this facility, that distributes naloxone to individuals at risk of overdose, I attest to the following:
Primary Contact's Title

1. Our facility has implemented the distribution of naloxone to individuals at risk of overdose as identified through this facility's policy, on or before February 1, 2024.

_____**Initial**

2. I understand that I will need to submit a complete roster of staff names who have completed the necessary training and dates of completion.

_____**Initial**

3. I understand the in-person or online training must cover at minimum the following competency topics:

    a. Staff ability to identify and utilize non-stigmatizing language regarding opioids;
    b. Staff ability to identify the signs and symptoms of opioid overdose;
    c. Staff ability to demonstrate how to administer naloxone based on naloxone product distribution (i.e., intranasal and/or intramuscular application); and
    d. Staff ability to identify methods of reducing future risk of opioid overdose.

_____**Initial**

4. I understand that the Naloxone Distribution Program Manager is responsible for hospital/ED NDP operations, including developing and maintaining:

    a. A list of all naloxone formulations approved for distribution to patients discharged from the hospital/ED;
    b. Institution-specific naloxone kit distribution tracking/logging protocols;
    c. Documentation standards for patient records, including patient screening, patient education, and naloxone distributed;
    d. Staff education, including evaluation of competency for naloxone administration; and
    e. Consultation with the hospital/ED pharmacy director regarding pharmacy regulations that impact their NDP.

_____**Initial**

5. That the information herein is current, complete, and accurate to the best of my knowledge, and it includes AHCCCS ID(s), National Provider Identification Number(s), and Provider Type(s). I understand that failure to complete this document accurately and in its entirety will result in AHCCCS' non-acceptance of this document.

_____**Initial**

6. The below AHCCCS IDs are one of the following provider types: Hospitals Subject to APR-DRG (PT 02), Critical Access Hospitals (PT 02), IHS and 638 Tribally Owned and/or Operated Facilities (PT 02), or Freestanding Emergency Departments (PT ED).

_____**Initial**

Provider AHCCCS ID (6 digits)	Provider Type	National Provider Identification Number (NPI)

Signature: _____

Date: _____