Jefferson County Juvenile Court
Family Dependency Treatment Court

Physician Waiver

I, _____ am currently a participant in the Jefferson County Family Dependency Treatment Court Program, in which I am receiving treatment for substance abuse. I am required to inform ALL medical care providers of my participation in the Program and request that, to the extent possible, I not be prescribed narcotic or other addictive medications. Before I may accept a prescription from you for ANY medication, I must have you, as the treating physician, sign below that I have made you aware of my substance abuse treatment.

Diagnosis/Procedure: _____

_____

Current Prescription Dosage Quantity Refills

1. _____

2. _____

3. _____

I understand the above guidelines for FDTC participation.
The medications I have prescribed are medically necessary and there are no effective non-addictive alternatives.

_____

Treating Physician Date