MARYLAND
Prescription Drug Affordability Board

16900 Science Drive
Suite 112-114
Bowie, MD 20715
pdab.maryland.gov

REQUEST FOR WAIVER

I request a waiver of the FY 2022 Prescription Drug Affordability Fund Assessment because the assessment exceeds 1% of my entity's most recently closed tax year: ____ .

In support of this request I state:

1. I,_____(name) am over 18 years of age and am competent to make this request.
2. I am the/a_____(position title) for the assessed entity and the following information is true and correct:

   Assessed Entity Name: _____

   Contact E-mail: _____

   Contact Phone: _____

   Address: _____

   Invoice Number: _____

   Permit/NAIC Number(s): _____

   FEIN Number: _____

3. The FY 2022 Prescription Drug Affordability Fund Assessment exceeds 1% of my organization's Maryland revenue in the most recently completed tax year: ____ (year).
4. I have attached the following documentation in support of my statement concerning the assessed entity's revenue and in support of this request (please check):

   _____ Relevant pages from Maryland or federal income tax return and supporting schedules.

   _____ Other (please specify below):

I solemnly affirm under penalty of perjury that the contents of this document are true and accurate to the best of my knowledge, information and belief.

_____ _____
Signature Date

_____
Printed Name