



Vermont Prescription Monitoring Program
 Vermont Department of Health
 Division of Alcohol and Drug Abuse Programs
 108 Cherry Street, PO Box 70
 Burlington Vermont 05402-0070
 {fax} 802-651-1573

**STATE LICENSING BOARD REQUEST FOR DISCLOSURE OF
 INFORMATION FROM
 THE VERMONT PRESCRIPTION MONITORING SYSTEM**

Please provide the information requested below. Use full names -- not initials or abbreviations. Please print

Full Name of Licensee	<i>Licensee DEA Number (if applicable)</i>
Street Address	Telephone Number (including Area Code)
City, State, Zip Code	Telephone Number (including Area Code)
Name of State Entity	
Residence Street Address (Home)	Office Street Address (Work)
City, State, and Zip Code	

*****Specific time period to be covered in report: From ___/___/___ through ___/___/___ (MM/DD/YY)**
(For prescriber reports, please include full name and DEA number)

I certify that the request is pursuant to a bona fide specific investigation of the licensee

Requestor's Printed Name	_____
Requestor's Signature	Date

I certify that I am duly designated by the board of licensure to make the request

Requestor's Signature	Date
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(The original, signed form shall be delivered by secure mail, fax, or in person to the Department, Division of Alcohol and Drug Abuse Programs office. The Department will transmit the information by secure mail or fax.)

For us of VPMS office only

Date Received	Date of Action
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Full Name of Licensee: _____

DEA Number: _____

Report to include the following information: (please check)

_____ The name of the drug dispensed

_____ The National Drug Code Number for the drug and dosage dispensed

_____ The date dispensed

_____ The quantity and dosage dispensed

_____ The number of days' supply dispensed

_____ The number of refills prescribed

_____ The prescriber's name

_____ The prescriber's DEA number, including suffix if applicable

_____ Pharmacy Name and location

_____ De-identified patient information (Example: Patient 1, Patient 2, Patient 3)