



Vermont Prescription Monitoring System
Board of Medical Practice
Request for Disclosure of Information Form

{Secure Fax Number} 802-652-2019

Name of Requester

Email Address

Telephone Number

BMP Case Number

I certify that the request is pursuant to a bona fide specific investigation identified by the BMP Case Number above and that I am duly designated by the Board of Medical Practice to make the request; and that the information requested is the minimum necessary to accomplish the intended purpose of the request:

Requestor's Signature

Date

REQUEST PARAMETERS

1. Information Requested about Prescriptions Written by a Licensee

Name and Practice Address of Licensee

DEA Number (if applicable)

2. Information Requested about Prescriptions Written for the Named Individual(s)

Empty box for information requested about prescriptions written for the named individual(s).

3. REQUIRED: Specific time period to be covered in report: From ___/___/___ through ___/___/___ (MM/DD/YY)

4. Information can be limited to the following drug(s)

Empty box with lines for listing drug(s) to which information can be limited.

For VPMS office use only

Date Received

Date of Action

BMP Case Number: _____

Report to include the following information: (Please check)

_____ **Information about a Licensee's use of the VPMS: Licensee** _____

_____ **Is this licensee registered with the VPMS?**

_____ **If yes, do they have delegates? If yes, please name** _____

_____ **Number of searches by licensee during the period** _____ **to** _____

_____ **Number of searches by delegate during the period** _____ **to** _____

_____ **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 (or specific pharmacy name/location: _____)**

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

_____ **De-identified patient age information**

_____ **We hereby request that the information be provided with all of the available patient identifying information. The information requested is the minimum necessary to accomplish the intended purpose of this investigation.**

Signature of the Executive Director: _____

Notes: _____
