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)

☐ 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)


For VPMS office use only

Date Received

Date of Action
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:____________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

v.10.2016