# Vermont Prescription Monitoring System
## Office of Professional Regulation

### Request for Disclosure of Information Form

**Secure Fax Number**: 802-652-2019

<table>
<thead>
<tr>
<th>Name of Requester</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Number</td>
<td>Case Number</td>
</tr>
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</table>

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

<table>
<thead>
<tr>
<th>Requestor’s Signature</th>
<th>Date</th>
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</table>

## REQUEST PARAMETERS

1. **Information Requested about Prescriptions Written by a Licensee**

<table>
<thead>
<tr>
<th>Name and Practice Address of Licensee</th>
<th>DEA Number (if applicable)</th>
</tr>
</thead>
</table>

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)**

   [List of drugs]

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**For VPMS office use only**

<table>
<thead>
<tr>
<th>Date Received</th>
<th>Date of Action</th>
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</table>
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 Chief Investigator: __________________________________________________________

Notes: __________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________