DC HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

# DELEGATE PDMP REGISTRATION FORM

**INSTRUCTIONS**

A prescriber or dispenser authorized to access prescription monitoring data may delegate his or her authority to access the data to up to two (2) health care professionals who are:

- Licensed, registered, or certified by a health occupations board; and
- Employed at the same location and under the direct supervision of the prescriber or dispenser.

**Registration Steps:**

- ☐ Complete the entire form. All fields are required unless marked "optional."
- ☐ Both the delegate and the delegate's supervisor must sign the form.
- ☐ Scan and save the form to your computer.
- ☐ Obtain an electronic copy of your non-expired government issued ID.
- ☐ Email the completed form and copy of your ID to the DC PDMP inbox at doh.pdmp@dc.gov

Registration as a delegate shall expire on June 30th of each even-numbered year or at any time the agent leaves, or otherwise becomes ineligible to receive information from the Program.

**Registrations will generally be processed within 10 business days.**



899 North Capitol Street NE | 2nd Fl, Washington, DC 20002 | E doh.pdmp@dc.gov | https://dchealth.dc.gov/pdmp



Revised 03/05/2020

DC HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

# DELEGATE PDMP REGISTRATION FORM

DC rules governing delegate access to Prescription Drug Monitoring Program data can be found at 17 DCMR § 10306.7.

**REQUESTING DELEGATE – All fields in this section are required.**

**1**. Name: _____ _____ _____
First Middle Last

**2.** Position/Title: _____ Health Occupation Board License Number: _____

**3.** Primary work location: _____
Street Address City, State Zip Code

**4.** Office Phone: (_____) _____ _____ Email: _____

**5.** Supervisor's Name: _____ Supervisor's Email: _____

**6.** Supervisor's Office Phone: (_____) _____ _____

**7. By checking the items below and signing this form, I understand that PDMP information shall only be accessed on an existing or new patient for the purpose of:**

☐ Establishing a prescription history to make informed treatment or dispensing decisions;

☐ The medical care or treatment of the patient about whom prescription monitoring data is being requested; or

☐ Performing due diligence and exercising professional judgment when presented with a prescription to dispense a covered substance for use by the patient about whom prescription monitoring data is being requested.

**Signature of Requesting Delegate: _____ Date: _____**

☐ As the supervisor, I attest that the applicant is my designated delegate and confirm that the applicant is eligible to review PDMP reports.

**Signature of Requesting Delegate's Supervisor: _____ Date: _____**

***REQUESTS THAT ARE UNSIGNED OR INCOMPLETE WILL BE REJECTED.***



899 North Capitol Street NE | 2nd Fl, Washington, DC 20002 | E doh.pdmp@dc.gov | https://dchealth.dc.gov/pdmp



Revised 03/05/2020