LAW ENFORCEMENT PDMP RECORDS REQUEST FORM

INSTRUCTIONS

The District of Columbia Prescription Drug Monitoring Program (PDMP) may provide reports for law enforcement or regulatory purposes. An individual shall be registered with the Program as an authorized agent entitled to receive reports.

A request for records as an authorized agent shall be accompanied by:

- An attestation from the applicant's employer confirming the identity of the applicant and the applicant's eligibility to receive the reports; and
- An attestation from the applicant that the prescription data will not be further disclosed and will be used only for the purposes stated in the request and in accordance with the law.

Records Request Steps:

- ☐ Complete the entire form. All fields are required unless marked "optional".
- ☐ Both the requester and the requester's supervisor must sign the form.
- ☐ Scan and save the form to your computer.
- ☐ Email the completed form to the DC PDMP inbox at doh.pdmp@dc.gov
- ☐ Electronically submit a New Report request in the DC PDMP AWARxE database at https://districtofcolumbia.pmpaware.net

Requests 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

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DC rules governing disclosure of DC Prescription Drug Monitoring Program data for law enforcement and regulatory purposes can be found at 17 DCMR § 10307.

REQUESTING OFFICIAL – All fields in this section are required.

1. Name: _____ _____ _____
First Middle Last

2. Title: _____

3. Case Number: _____

4. By initialing each of the following, I attest that the statements are true and correct to the best of my knowledge.

_____ As the requesting official, I attest that I am either a law enforcement or regulatory official engaged in an ongoing investigation.

_____ I attest that I am requesting the following information as part of an existing bona fide investigation, to which I have been assigned, in which a report of suspected criminal activity involving a patient, prescriber or dispenser has been made.

_____ I attest that the information sought is relevant and material to such investigation and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought.

REPORT DETAILS – All fields in this section are required.

5. Date Range for Report: From (mm/dd/yyyy):_____ To (mm/dd/yyyy): _____

6. Please check the PDMP profile being requested: ☐ Patient ☐ Prescriber ☐ Dispenser

PATIENT INFORMATION – Complete this section for "Patient" profiles.

7. Full Name: _____ _____ _____
Last/Family First Middle

8. Address (optional): _____

_____ _____ _____
City State Zip Code

9. Date of Birth (mm/dd/yyyy): _____

(CONTINUE)

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10. Does the patient use any other names, addresses, or birthdates (optional)? Yes ☐ No ☐ If yes, list below:

_____

PRESCRIBER INFORMATION - Complete this section for "Prescriber" profile requests.

11. Prescriber Full Name: _____
(Example: JOHN DOE, M.D.)

DEA Number: _____ DC CS Number: _____

DISPENSER INFORMATION - Complete this section for "Dispenser" profile requests.

12. Dispenser Full Name: _____
(Example: ACME PHARMACY or JOHN DOE, M.D.)

DEA Number: _____ DC CS Number (if applicable): _____

13. By checking the items below and signing this form I certify that I agree and understand that:

☐ Prescription monitoring data received from the Program shall not be further disclosed and the prescription data shall only be used in accordance with the law;

☐ All prescription monitoring data collected, maintained, or submitted pursuant to this Program is confidential, privileged, not subject to discovery, subpoena, or other means of legal compulsion in civil litigation, and is not a public record;

☐ The prescription monitoring database may contain errors resulting from the reporting of information received. Independent verification of patient information with pharmacies and prescribers may sometimes be prudent or necessary.

Signature of Requesting Official: _____ Date: _____

Signature of Requesting Official's Supervisor: _____ Date: _____

REQUESTS THAT ARE UNSIGNED OR INCOMPLETE WILL BE REJECTED.

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