COMMONWEALTH OF VIRGINIA

Virginia Department of Health Professions

Prescription Monitoring Program

Perimeter Center

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
Phone: (804) 367-4514
Fax: (804) 527-4470
Email: pmp@dhp.virginia.gov
Website: www.dhp.virginia.gov

REQUEST TO REGISTER AS AN AUTHORIZED AGENT TO RECEIVE INFORMATION FROM THE PRESCRIPTION MONITORING PROGRAM

Please provide the information requested below. (Print or Type) Use full name not initials

Name:	**Position:**	
Agency Name (Please Circle): DEA/DHP/HPMP/MEO/MFCU/DMAS/FBI	**Agent ID:** ____________	
Street Address	**City**	
State Virginia	**Zip Code**	**Work Area Code and Telephone Number**
Fax Number:	**Email Address:**	**Date of Birth:**

I hereby attest that I am eligible to receive reports under §54.1-2523 (B) or (C) of the Code of Virginia from the Prescription Monitoring Program.
Sign Here and below:

Signature: **Date:**

<u>AFFIDAVIT</u>

(To Be Completed Before a Notary Public)

(Printed Name) ____________________________________ certifies that he is the person referred to in this application for registration with the Prescription Monitoring Program and that the information provided is factual and complete.

____
Signature of Applicant

Subscribed and sworn to me, a notary public in and for the Commonwealth of Virginia at large, on this ________day of ____________________, _______. My commission expires on _______________, __________

____
Signature of Notary Public

I hereby attest that _______________ is known to me and is an employee of ____________________________ entitled to receive reports from the Prescription Monitoring Program pursuant to §54.1-2523 (B) or (C) of the Code of Virginia.

Title: _____________________________________ Printed Name: _____________________________

Signature: ____ Date: ____________________________

Subscribed and sworn to me, a notary public in and for the Commonwealth of Virginia at large, on this

________day of ____________________, _______. My commission expires on _______________, ______

____

Signature of Notary Public

Registration as an agent authorized to receive reports shall expire on June 30 of each even-numbered year or at any time as the agent leaves or alters his current employment or otherwise becomes ineligible to receive information from the program.

For Department Use Only

Date Received:	Director or Designee Signature:	Date Completed: