



# COMMONWEALTH OF VIRGINIA

## Department of Health Professions

### Prescription Monitoring Program

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Richmond, Virginia 23233

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Email: [pmp@dhp.virginia.gov](mailto:pmp@dhp.virginia.gov), Web site: [www.dhp.virginia.gov](http://www.dhp.virginia.gov)

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

**APPLICANT:** Please check either *PHARMACIST DELEGATE*  or *PRESCRIBER DELEGATE*   
Please provide the information requested below. (Print or Type) Use full name not initials.

Name:		Position and License, Registration or Certification Number (if licensee):	
Organization/Business Name		Date of Birth:	
Street Address		City	
State	Zip Code	Work Area Code and Telephone Number	
Fax Number:		Email Address:	

I hereby attest that I am eligible to receive reports under §54.1-2523.2 of the Code of Virginia from the Prescription Monitoring Program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

What is the name of the city you were born in? \_\_\_\_\_

What is your Mother's maiden name? \_\_\_\_\_

What is your favorite color? \_\_\_\_\_

**SUPERVISOR ATTESTATION:**

I hereby attest that \_\_\_\_\_ is employed at above named facility, is under my supervision, and is licensed, registered, or certified by a health regulatory board under the Department of Health Professions or in another jurisdiction entitled to receive reports from the Prescription Monitoring Program as my delegate pursuant to §54.1-2523.2 of the Code of Virginia. If not a licensee, \_\_\_\_\_ has routine access to confidential patient data and has signed a patient data confidentiality agreement.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

DEA NUMBER(Prescriber): \_\_\_\_\_ LICENSE NUMBER (Pharmacist): \_\_\_\_\_

**For Department Use Only**

Date Received:	Date Completed:	Registration Number Assigned:
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