

State of Michigan
 Department of Community Health
 Michigan Automated Prescription System (MAPS)
 P.O. Box 30454, Lansing, Michigan 48909
 Phone: 517/373-1737 Fax: 517/241-5072 Email: Mapsinfo@michigan.gov
 MAPS Online: <https://sso.state.mi.us>
REQUEST FOR MAPS REPORT – Practitioner/Pharmacist

Patient Full Name: _____
First M.I. Last

Address: _____

City/State/Zip: _____

Date of Birth: _____ SSN or Driver's License #: _____

Aliases and Other Addresses (if known): _____

Report Period Requested From: _____ to _____
Date Date

REQUIRED: Provide a brief summary of the facts and circumstances under which you are requesting information regarding this patient.

(If you need additional space, please continue on the reverse side of this form.)

Please Circle One:

Practitioner Pharmacist Physician Assistant Nurse Practitioner

Name (print): _____

Michigan License #: _____

DEA #: _____

Address: _____

City/State/Zip: _____

Telephone #: () _____ FAX #: () _____

Delegating Physician Name and DEA# (only required for P.A. and N.P.): _____

I certify that this information shall be used for the purpose of providing medical or pharmaceutical treatment to a ***bona fide current patient***. I shall not provide this information to any other person or entity except for other practitioners who are treating this patient.

Signature: _____
(original handwritten signatures only-stamped signatures are not allowed)