

**Maryland Prescription Drug Monitoring Program (PDMP)
MDH Agency Data Request Form**

Data Requester (must be trained in PDMP data requests)

Name / Title: _____

MDH Agency: _____

Work Phone #: _____

Email: _____

Investigation Information

1. Request Type: Patient Prescriber Dispenser

2. Case #: _____

3. Name of Query Target: _____

(First/Last for Patient, optional
for Prescriber, Dispenser)

4. Date of Birth of Query

Target: (Required for Patient
query only)

5. DEA #: _____

(Required for Prescriber &
Dispenser if no name
provided)

6. Query BEGIN Date: _____

(MM/DD/YYYY)

7. Query END Date: _____

(MM/DD/YYYY)

For completion by MDH Secretary, or approved designee

By signing, I approve this request for processing by the Maryland PDMP.

MDH Secretary, or designee (signature)

Date

Name of approved designee (Deputy Secretary or Chief of Staff only)

Requester, briefly provide background on the investigation:

A large, empty rectangular box with a black border, intended for the requester to provide background information on the investigation.