Instructions:

1. Complete all fields, Incomplete requests will be returned.
2. The practitioner making the request, must sign the request. **STAMPED SIGNATURES ARE NOT ACCEPTED.**
3. Fax or mail this form to NDPDMP, Board of Pharmacy's office.

Fax Number: (701) 877-2405

Mailing Address: ND State Board of Pharmacy
Attn: PDMP
1838 E Interstate Ave Suite D
Bismarck, ND 58503

4. Please call the board's office if you have any questions regarding the prescription drug monitoring program. (701) 877-2410

Profile Request - Pharmacy

North Dakota Prescription Drug Monitoring Program (NDPDMP)
North Dakota Board of Pharmacy
Patient Profile Request For Controlled Substance Prescription Information

Contacts:
Mark J. Hardy PharmD, Executive Director, ND Board of Pharmacy:
mhardy@ndboard.pharmacy
Kathy R. Zahn, Program Administrator, Prescription Drug Monitoring Program,
pdmp@ndboard.pharmacy

PATIENT'S DETAILS

Name: _____ Date of Birth: _____

Address: _____ AKA (if any): _____

City, State, Zip: _____ Date Range: _____

Up to 3 years from the date processed (ex. All, or Jan2019-present)

PHARMACIST DETAILS

Name: _____ Personal License No.: _____

Pharmacy Name: _____ ND Pharmacy Permit No.: _____

Address: _____ Phone No.: _____

City, State, Zip: _____ Fax No.: _____

☐ CHECK THE BOX IF YOU WOULD PREFER THE REPORT MAILED TO YOU, AND NOT FAXED.

Mailing Address, if different from above: _____

By signing and dating this form, I certify this patient is under my care or has requested care from the above listed pharmacy. I affirm that all information on this form is true and that all requests will be used for legitimate purposes. All data obtained from the ND PDMP will be treated as protected health information and handled in accordance with federal and state laws.

X _____
SIGNATURE DATE

For Office Use Only

Date/Time Rec'd: _____ Date/Time Faxed/Mailed: _____

Prepared By: _____
Signature

Notes:

04.23.2019