Patient's Request for PMP Information

Print clearly

Date: _____
Patient Name: _____
Current Address: _____
City: _____
State: _____
Zip Code: _____
Current Day-Time Phone #: _____
Date of Birth: _____
Gender: ☐ Male ☐ Female

Iowa Board of Pharmacy
400 SW 8th Street, Suite E
Des Moines, Iowa 50309-4688
Phone: 515-281-5944

Aliases
Alias #1: _____
Alias #2 _____
Alias #3: _____

Other Addresses:

Address: _____
City: _____
State: _____
Zip Code: _____

Address:
City: _____
State: _____
Zip Code: _____

Date Range of Prescriptions Requested:

☐ Last 12 months Begin Date: _____ End Date: _____

Request may be personally delivered to Terry Witkowski or Jennifer Tiffany at the offices of the Board located at 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50 309-4688. Patient will be required to present current government-issued photo identification at the time of the delivery of the request. A copy of the patient's identification shall be maintained in the records of the PMP.

A person who is unable to personally deliver the request to the Board offices may submit a request via mail or commercial delivery service. The request shall be a sworn, signed statement witnessed by a currently registered notary public with a copy of the patient's government-issued photo identification. The notary public shall certify the copy of the patient's government-issued photo identification by including and completing the following certification statement on the page containing the copy (the attached page may be used for photo ID copy and Notary certification):

> *"State of __, County of ____.*
> *I, _____, a Notary Public, certify this __ day of ____, 20_, the foregoing document is a true, correct, complete, and unaltered copy of (describe photo ID), made by (name the individual who made the copy).*
> *[Notary Public's signature and commission expiration date]"*

I, _____*(patient)*, hereby certify that the information provided is true and correct, that all names and addresses used by me during the date range indicated have been provided, and that I am the individual whose information I am requesting.

_____
Signature of Patient

_____
Date

State of _____

County of _____

Signed and sworn to (or affirmed) before me on _____ day of _____, 20___, by _____.
Name of Patient

_____ _____
Signature of Notary Public *Commission Expiration Date*

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(Copy of photo identification must be copied directly to this page; a copy cut from another page and affixed hereto is not acceptable.)

"State of _______, County of _____.
I, _____, a Notary Public, certify this ___ day of _____, 20__, the foregoing document is a true, correct, complete, and unaltered copy of _____, made by _____.
(*describe photo ID*) (*name the individual who made the copy*)

_____ _____
Signature of Notary Public Commission Expiration Date