

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

REQUEST FOR MAPS REPORT – Law Enforcement/Government Agency/Other

Physician/Pharmacy or Patient Full Name: _____			
	First	M.I.	Last
Address: _____			
City/State/Zip: _____			
Date of Birth: _____	MI License #: _____	DEA #: _____	
	(if applicable)	(if applicable)	
SSN or Driver's License Number (if applicable): _____			
Aliases and Other Addresses (if known): _____			
Report Period Requested From: _____ to _____			
	Date	Date	
Report Format Preferred: PDF Excel WinZip			
Provide a brief summary of the facts and circumstances under which you are requesting information regarding this practitioner or patient. An open case number is required.			
Case #: _____			
(If you need additional space, please continue on the reverse side of this form.)			
Agency Name: _____			
Address: _____			
City/State/Zip: _____			
Telephone Number: _____		FAX Number: _____	
Authorized Individual Name (print): _____			
Signature and Title of Authorized Individual: _____			
I certify that this information shall be used only for bona fide drug-related criminal investigatory or evidentiary purposes; or for the investigatory or evidentiary purposes in connection with the functions of a disciplinary subcommittee of one or more of the licensing or registration boards created under Article 15. I shall not provide this information to any other person or entity except by order of a court of competent jurisdiction.			
<small>The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency. Authority: P.A. 231 of 2001 Completion: Voluntary</small>			
For Department of Community Health use only:			
Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No Signature: _____ Date: _____			