



Bureau of Professional Licensing
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REQUEST FOR MAPS REPORT – Practitioner/Pharmacist

Authority: P.A. 231 of 2001
 Completion: Voluntary

REQUEST INFORMATION			
First Name		Middle Name	Last Name
Street Address			
City		State	Zip Code
U.S. Social Security Number	Driver's License Number		Date of Birth (MM/DD/YYYY)
Report Period from _____ to _____ (Start Date) (End Date)		Aliases and Other Addresses (if known)	
REQUIRED: Provide a brief summary of the facts and circumstances under which you are requesting information regarding this patient and how it relates to controlled substance issues. _____ _____			
PROVIDER INFORMATION			
PLEASE CHECK ONE <input type="checkbox"/> PRACTITIONER <input type="checkbox"/> PHARMACIST <input type="checkbox"/> PHYSICIAN ASSISTANT <input type="checkbox"/> NURSE PRACTITIONER			
First Name		Middle Name	Last Name
Street Address			
City		State	Zip Code
Telephone Number with Area Code		Fax Number with Area Code	
Professional License Number		DEA Number	
Delegating Physician Name (only required for P.A. and N.P.)		Delegating Physician DEA Number (only required for P.A. and N.P.)	
CERTIFICATION			
I certify that this information shall be used only for the purposes of providing medical or pharmaceutical treatment to a <i>bona fide current patient</i> . I shall not provide this information to any other person or entity except by order of a court of competent jurisdiction.			
Signature (original handwritten signature only – stamped signatures are not allowed)			Date

The Department of Licensing and Regulatory Affairs 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.