



## MICHIGAN AUTOMATED PRESCRIPTION SYSTEM SOFTWARE INTEGRATION REQUEST

BUSINESS INFORMATION		
<b>Business Name</b>		
<b>Business Type (Choose One)</b>		
Health System	Number of Hospitals	
	Number of Offices	
	Number of Pharmacies	
	Number of Prescribers	
	Number of Pharmacists	
Hospital	Number of Prescribers	
	Number of Pharmacists	
Pharmacy	Number of Pharmacies	
	Number of Pharmacists	
Physician's Office	Number of Offices	
	Number of Prescribers	
<b>Street Address</b>		
<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Phone</b>	<b>Fax</b>	
<b>Business Website (If none, leave blank or enter N/A)</b>		
PRIMARY CONTACT INFORMATION		
<b>Name</b>		
<b>Phone</b>	<b>Email Address</b>	
IT CONTACT INFORMATION (IF IT ON STAFF)		
<b>Name</b>		
<b>Phone</b>	<b>Email Address</b>	
EMR/EHR/PHARMACY SOFTWARE INFORMATION		
<b>Vendor (If "Other," please provide contact information)</b>		<b>If "Other," please provide additional information here</b>
<b>Product Name</b>		
<b>Vendor Contact Name</b>		
<b>Phone</b>	<b>Email Address</b>	
<b>Install Type</b>		
On-Premise	Cloud	