

State of Michigan  
Department of Community Health  
Michigan Automated Prescription System (MAPS)  
P.O. Box 30202, Lansing, Michigan 48909  
Phone: 517/373-1737 Fax: 517/241-5072 Email: [Mapsinfo@michigan.gov](mailto:Mapsinfo@michigan.gov)  
MAPS Online: <https://sso.state.mi.us>.

**REQUEST FOR MAPS REPORT – Practitioner/Pharmacist**

Patient's Full Name: \_\_\_\_\_  
(First) (M.I.) (Last)

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN or Driver's License #: \_\_\_\_\_

Aliases and Other Addresses *(if known)*: \_\_\_\_\_

Report Period Requested From: \_\_\_\_\_ to \_\_\_\_\_  
Date Date

**REQUIRED:** Provide a brief summary of the facts and circumstances under which you are requesting information regarding this patient.

\_\_\_\_\_

\_\_\_\_\_

*(If you need additional space, please continue on the reverse side of this form.)*

**Please Circle One:**

Practitioner    
 Pharmacist    
 Physician Assistant    
 Nurse Practitioner

Name *(print)*: \_\_\_\_\_

Michigan License #: \_\_\_\_\_

DEA #: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone #: ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

Delegating Physician Name and DEA# *(only required for P.A. and N.P.)*: \_\_\_\_\_

I certify that this information shall be used for the purpose of providing medical or pharmaceutical treatment to a ***bona fide current patient***. I shall not provide this information to any other person or entity except for other practitioners who are treating this patient.

Signature: \_\_\_\_\_  
(original handwritten signatures only-stamped signatures are not allowed)

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