Alaska State Board of Pharmacy
Alaska Prescription Drug Monitoring Program
550 West 7th Avenue, Suite 1500
Anchorage, AK 99501-3567
Phone: (907) 269-8404 Fax: (907) 269-6003
Email: akpdmp@alaska.gov
Website: www.commerce.alaska.gov/occ/ppha.htm

AK PDMP ACCESS VERIFICATION

Instructions:

1. Please complete this form in full. *Incomplete requests will be returned.*
2. Go to http://rpt.pmp.relayhealth.com/ak/ and register at "Request Account".
3. Sign the completed verification form in the presence of a Notary Public and have them apply their seal to the signed original.
4. Mail the *original* notarized form to the AK PDMP office. The address is on the form. Keep a copy for yourself.
5. Attach a copy of your Driver's License, State Licensure and DEA Registration.
6. Do not forget to go to https://rpt.pmp.relayhealth.com/ak/ and register at "Request Account".

When the proper paperwork is received your account will be activated and you will be notified via the e-mail address you provided.

- If you need Technical Assistance please call 1-800-892-0333
- If you have a Policy Question please call 1-907-269-8404

Please provide the information requested below (print or type). Use full legal name, not initials.

Name: ____

State License Number: ______________ DEA Number: ______________ NPI # ______________

Address: ____

Phone: ______________________ Fax: ______________________

Email: ____

BY MY INITIALS, I ACKNOWLEDGE/AGREE TO EACH STATEMENT BELOW:

____ I certify that information requested from the Alaska Prescription Drug Monitoring Program will solely be used for the purpose of providing medical or pharmaceutical treatment or evaluating the need for such treatment to a current or potential patient.

____ Approved users are limited to information concerning a current or potential patient of the practitioner.

____ Any person authorized to obtain prescription information that knowingly discloses information for misuse or purposely alters the information are subject to, but not limited to, a civil or criminal penalty imposed as specified in AS 17.30.200(l).

____ I agree not to share my password and realize that any other such sharing is a violation of the law as stated under "Unlawful Disclosure" and such actions will be prosecuted to the fullest extent of the law.

____ I have read and agree to the Alaska Prescription Drug Monitoring Program Data Collection Website Terms of Use Agreement on the remaining pages of this application document.

CONTINUED ON REVERSE

____ I certify that the information contained is complete and accurate without evasion or misrepresentation.

____ As a prescriber or dispenser, I agree to notify the Alaska Prescription Drug Monitoring Program of any investigation or license suspension or license restrictions as it pertains to me.

____ I understand that inappropriate access or disclosure of information is a violation of Alaska law and may result in disciplinary action by my licensing entity; or loss of database access privileges. I agree to follow the policies of the Alaska Prescription Drug Monitoring Program and I also agree not disclose or misrepresent any data or protected health information to any unauthorized person or party.

I certify that the above information is correct.

SIGN HERE

____
Signature

____
Date

(NOTARY SEAL)

SUBSCRIBED AND SWORN to before me,
a Notary Public, in and for the State of ________

this ______ day of _________________ , 20 _____.

NOTARY

____
My Commission Expires: ______________________

For Department Use Only			
Date Received:	☐ Approved ☐ Disapproved	Director or Designee Signature:	Date of Action:
Notes:			

08-4593 (09/2011)