User Registration Required Prior to Submitting Request

Complete form and return to:
Iowa Prescription Monitoring Program
400 SW 8th Street, Suite E
Des Moines, IA 50309-4688
Phone: 515-281-5944
Fax: 515-281-4609

Submit Request

User Information:

Requester's Category

User Name

LE Badge Number

How do you wish to receive the information

Information Being Requested On:

Patient

Last Name

First Name

Middle Name

Address

City State Zip Code

DEA Number

SSN

D.O.B.

Gender

Home Number

Work Number

Aliases/Other Family Members Who are Patients:

Alias	Last Name	First Name	Middle Name	D.O.B .
☐				
☐				
☐				

Date Range of Prescriptions Requested:

☐ Last 12 Months Begin Date _____ End Date _____

mm/dd/yyyy mm/dd/yyyy

Certification -- Law Enforcement:

I certify that the information requested is related to a specific investigation of a specific individual and supported by a determination of probable cause.

Signature of Requesting Officer or the Officer's Superior Date:

_____ _____

This request must be accompanied by an order, subpoena, or warrant issued by a court or legal authority that requires a determination of probable cause.

Certification -- Regulatory Agency:

I certify that the information requested is related to a specific investigation of a specific individual and is supported by a determination of probable cause.

Signature of Requesting Officer or the Officer's Superior Date:

_____ _____

This request must be accompanied by an order, subpoena, or other form of legal compulsion establishing that the request is supported by a determination of probable cause.

Report Format: ◯ EXCEL ◯ PDF

Print Form