

APPLICATION FOR ONLINE ACCESS BY OUT-OF-STATE LICENSEE

INSTRUCTIONS:

Direct online access to the Montana Prescription Drug Registry (MPDR) may be granted to a pharmacist or prescriber (Dentist, Physician, Naturopathic Physician, Optometrist, Physician Assistant, Podiatrist, Resident Physician, and Advanced Practice Registered Nurse with Prescriptive Authority), and to a designated representative of the Montana Medicare or Medicaid programs, Tribal Health, Indian Health Service, and Veterans Administration. **NOTE: If you have a Montana license and authority to prescribe or dispense controlled substances, you must register as a Practitioner, not as an Out-of-State Licensee (see more information at www.mpdr.mt.gov).**

To access registry information, each Out-of-State licensee must :

1. Complete this Request Form / Confidentiality Agreement. Submit the application and required attachments to the Montana Prescription Drug Registry via email to dlibsdpdr@mt.gov
 - a. All applications must include proof of identification (a legible copy of your driver's license, passport or other government-issued photo identification).
2. Review the [MPDR AWAxRxE Registered User Guide](#).

MPDR Staff will independently verify your licensure and send further instructions to the email address entered below. Access is granted only to individuals, not to organizations. Each individual must apply separately to gain access to the MPDR, and each user will be issued one ID and password for their use, regardless of where they are physically located. In other words, an individual who works at multiple locations will receive one ID/password for use at all locations.

APPLICANT INFORMATION:

Please print or type.

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Social Security Number or Foreign ID: _____

My DEA# (if applicable): _____

State issuing my license to practice: _____ My license number: _____

EMPLOYER INFORMATION:

This section should include contact information for the location where you spend the majority of your working hours. The email address listed in this section will be used for all communications from the MPDR. Please print or type.

Employer Name: _____

Employer Address: _____

City, State, Zip: _____

My Work Phone Number: _____ My Mobile Phone#: _____

My Email Address for MPDR Correspondence: _____

APPLICANT'S ROLE - Check one of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> I am a Pharmacist | <input type="checkbox"/> I am a Physician Assistant | <input type="checkbox"/> I am an Optometrist |
| <input type="checkbox"/> I am a Physician | <input type="checkbox"/> I am a Podiatrist | <input type="checkbox"/> I am a Medical Resident |
| <input type="checkbox"/> I am a Dentist | <input type="checkbox"/> I am a Psychologist with Prescriptive Authority | |

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I am a Naturopathic Physician I am an APRN with Prescriptive Authority
 I represent a Medicaid Fraud Unit I am a Medicare or Medicaid Administrator
 Other: _____

TERMS OF ACCOUNT USE AND CONFIDENTIALITY AGREEMENT:

Read and initial each of the following statements:

- If employed by a government agency, I am authorized by my agency to access the MPDR for the sole purpose of monitoring participants in the Agency's program(s).
- I agree to notify the MPDR staff immediately (within one business day) when I leave the place of employment identified on this application form OR when my job duties no longer relate to the MPDR.
- I understand that information accessed and/or reviewed through the Montana Prescription Drug Registry (MPDR) program is confidential and constitutes protected health information (PHI). I am therefore responsible for the security and confidentiality of patient history reports available to me. I agree to use the reports only for the purpose of providing care to my patients and patients referred to me for care.
- I understand that information obtained from the MPDR can be part of the patient's medical record and should be treated with the same confidentiality protection as I would treat any other patient's record.
- I agree not to disclose any data or PHI to any unauthorized person or party.
- I have completed the MPDR's online training program which includes information on privacy and security.
- I agree that I will not share my user account information, login name or password with any person, regardless of whether that person is also an authorized user of the MPDR.
- I understand that I must report any potential and/or identified misuse of MPDR searching or data to the MPDR program and/or the registered user's licensing board (Mont. Code Ann. 37-7-1513(2)).

I hereby attest that I understand the terms of access and confidentiality of the MPDR and I will abide by these terms. Violation of any of the terms of this agreement may result in revocation of access to the MPDR, disciplinary action may be taken by my licensing board, and I may be liable for a civil penalty of up to \$10,000 for each violation (MCA 37-7-1513) in addition to other sanctions provided by law.

Signature: _____ Date: _____
Print Name: _____

FOR USE BY MPDR STAFF ONLY:

Agency Contacted: _____
Source of Contact Information: _____
Licensure Verified: _____
Application Approved: Yes No Determination By: _____ Date: _____
Denial Reason: _____