INDIANA PRESCRIPTION MONITORING PROGRAM
402 W. Washington Street, Rm. W072 • Indianapolis, IN 46204
OFC: (317) 234-4458 • FAX (317) 233-4236 • www.in.gov/inspect

INSPECT
Indiana Scheduled Prescription Electronic Collection & Tracking

PRACTITIONER REGISTRATION / RE-AUTHENTICATION FORM

☐**New User** ☐**Update User Info**

Each user granted access to INSPECT holds a position of trust and must preserve the security and confidentiality of the INSPECT data he/she uses. INSPECT approved users must meet specific eligibility requirements and must abide by all applicable federal and State guidelines including, but limited to, IC-35-48-7and The Health Insurance Portability and Accountability Act of 1996 (HIPPA). Misuse of INSPECT data constitutes a criminal offense and may result in the suspension/revocation of a registered accountholders access privileges, or, in some cases, action against the offending accountholder's professional license and/ or agent. Registered accountholders wishing to reinstate their INSPECT account access privilege must formally petition the Controlled Substances Advisory Committee (CSAC).

PLEASE PRINT

_____ Requestor Name

_____ State Board License (Professional License Number)

_____ Drivers License Number

_____ DEA # (Practitioner)
*Pharmacist can leave this blank **REQUIRED to all other Professions.

Please select your occupation:

☐ Doctor of Medicine ☐Osteopathic Physician ☐Doctor of Dental Medicine/Surgery
☐ Podiatrist ☐ Physician Assistant ☐ Certified Nurse-Midwife ☐ Nurse Practitioner
☐Clinical Nurse Specialist ☐Veterinarian ☐ Registered Pharmacist ☐_____

_____
Primary Residence Address

City:_____ State:_____ Zip:_____

_____ Telephone Number (including area code)
_____ Cell/Other Number (including area code)
_____ Fax Number (including area code)

_____
E-mail Address **(Provide a secure personal email address for the registering individual) **REQUIRED**

_____
Residence Address Listed on Driver's License (if different from above)

City:_____ State:_____ Zip:_____

I certify that the information I request will be kept confidential, and I understand that I will be held libel for any breach of that confidentiality.

_____ Signature of Affiant
_____ Date

STATE of _____
COUNTY OF_____

AFFIDAVIT

Before me, the undersigned authority in and for the State of _____, personally appeared.

_____,
Who is known to me and who after being first duty sworn deposes and says that the above and foregoing document is true and correct to the best of his/her knowledge, information, and belief formed after reasonable inquiry.

Subscribed and sworn to before me this_____ day of_____,20_____.

Notary Public Seal
Notary Public Signature_____

FOR DEPARTMENT USE ONLY			
Date Received	☐ Approved ☐ Disapproved	Staff Signature	Date of Action