Florida's Prescription Drug Monitoring Program
4052 Bald Cypress Way, Bin C-16
Tallahassee, FL 32399
Phone: (850) 245-4797
Fax: (850) 617-6430
e-forcse@flhealth.gov

Agency Administrator Appointment Form

In accordance with section 893.055, Florida Statutes (F.S.), local, state, and federal law enforcement agencies engaged in an active investigation regarding potential criminal activity, fraud, or theft regarding prescribed controlled substances, State Attorney General and Florida medical examiners may request controlled substance prescription dispensing information (Information) made confidential and exempt pursuant to section 893.0551, F.S. Please complete the fields below to identify an Administrator to appoint authorized users to request and receive Information on behalf of the agency. Please use this form to communicate any changes in E-FORCSE Administrator status.

FORM INSTRUCTIONS: New agency administrators: Upload the completed form to the agency administrator's registration request. Agency head or designee: To remove an appointment, email completed form to e-forcse@flhealth.gov.

<table>
<tr><td colspan="4">Please provide the information requested below. ALL fields are required. (Print or Type) Use full name not initials.</td></tr>
<tr><td colspan="4">Agency E-FORCSE Administrator Applicant Information ☐ New Appointment ☐ Remove Appointment</td></tr>
<tr><td colspan="4">Effective Date:</td></tr>
<tr><td colspan="2">Agency Name</td><td colspan="2">☐ Yes, I work in an undercover status at my agency and assert public record exemption in s. 119.071(4), F.S.
☐ No, I do not work in an undercover status.</td></tr>
<tr><td>Name</td><td colspan="2">Title</td><td>Employee ID Number</td></tr>
<tr><td colspan="2">Telephone Number</td><td colspan="2">Email Address</td></tr>
<tr><td colspan="4">____ (Initial) I confirm that all information on this form is true and that all appointments of authorized users will be made on behalf of this agency.
____ (Initial) I understand all information disseminated from the database in any form by the PDMP to any entity is considered protected health information and the use of it is governed by any and all applicable federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA).
____ (Initial) I understand it is my duty and responsibility to maintain the confidential and exempt status of any information I receive from the PDMP and that inappropriate access or disclosure of this information is a violation of section 893.0551, Florida Statutes, and a third-degree felony, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.</td></tr>
<tr><td colspan="2">Signature:

(Format for electronic signature: //John F. Doe//)</td><td colspan="2">Date:</td></tr>
<tr><td colspan="4">Agency Head or Designee Information</td></tr>
<tr><td colspan="2">Name</td><td colspan="2">Title</td></tr>
<tr><td colspan="2">Phone Number</td><td colspan="2">Email Address</td></tr>
<tr><td colspan="4">I confirm all information on this form is correct and that the individual above represents this agency and is authorized to appoint other individuals as authorized users to request and receive Information from E-FORCSE on behalf of this agency. I understand all information disseminated from the database in any form by the PDMP to any entity is considered protected health information and the use of it is governed by any and all applicable federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA).</td></tr>
<tr><td colspan="2">Signature:

(Format for electronic signature: //John F. Doe//)</td><td colspan="2">Date:</td></tr>
<tr><td colspan="4">For Department Use Only</td></tr>
<tr><td>Date Received</td><td>☐ Approved
☐ Denied</td><td>PDMP Staff Signature</td><td>Date of Action</td></tr>
</table>