INTEGRATION

REQUEST FOR INFORMATION

BUSINESS INFORMATION (*required)

Company*

Phone*

Address*

Address (Line 2)

City*

ZIP Code*

Business type*

# of Pharmacies

# of Qualified Pharmacists

# of Offices

# of Qualified Prescribers

# of Hospitals

Primary Software Vendor*

Primary Software Version*

Vendor Contact E-mail*

PRIMARY CONTACT

Name*

Job Title*

Phone*

E-mail*

IT CONTACT (IF ON STAFF)

Name

Job Title

Phone

E-mail

Please return completed form to INSPECT@pla.in.gov