

**MICHIGAN AUTOMATED PRESCRIPTION SYSTEM
 SOFTWARE INTEGRATION REQUEST**

BUSINESS INFORMATION		
Business Name		
Business Type (Choose One)		
Health System	Number of Hospitals	
	Number of Offices	
	Number of Pharmacies	
	Number of Prescribers	
	Number of Pharmacists	
Hospital	Number of Prescribers	
	Number of Pharmacists	
Pharmacy	Number of Pharmacies	
	Number of Pharmacists	
Physician's Office	Number of Offices	
	Number of Prescribers	
Street Address		
City	State	Zip Code
Phone	Fax	
PRIMARY CONTACT INFORMATION		
Name		
Phone	Email Address	
IT CONTACT INFORMATION (IF IT ON STAFF)		
Name		
Phone	Email Address	
SOFTWARE INFORMATION		
Vendor (If "Other," please provide contact information)		If "Other," please provide additional information here
Product Name		
Vendor Contact Name		
Phone	Email Address	
Install Type		
On-Premise	Cloud	
STATE AGENCY TO COMPLETE THE FOLLOWING SECTION		
Grant-Participant	Statewide-Participant	Total Amount: \$