

License Authorization Form

Prior to shipping prescription products (medical devices), we must have authorization from the physician (Medical Director) responsible for your department. Please fill in your customer information at the top of this form and then have your authorizing physician complete the box section. Send this completed form to us by email or mail along with copies of all requested licenses. If your agency does not have a Medical Director, but is licensed to purchase prescription products, please send us a copy of all applicable licenses along with this form for our review.

| Customer Name: | | | |
|--|--|--|--|
| Contact Person: | | Contact Email: | |
| Telephone Number: | | Fax Number: | |
| Shipping Address: | | | |
| City: | State: | Zip: | |
| Additional Shipping Locations: attach a list of approved location | • | al devices to be shipped to | multiple addresses initial here and |
| Customer License Information (| Must attach copies of al | l applicable licenses): | |
| State EMS of Pharmacy License Number: | | | Exp. Date: |
| State Controlled Substance License Number: | | | Exp. Date: |
| Federal DEA License Nu | mber: | | Exp. Date: |
| | | | |
| ** | *THIS SECTION TO BE CO | OMPLETED BY MEDICAL DII | RECTOR*** |
| Include additional information a Medical Device Aut Limited Authorization | nd approvals where nechorization Only. Absolut | essary. tely No Medications! dications and Medical Dev | hase of devices for the above facility. ices Only: (Please list) |
| By signing below, I hereby auth approved devices. (Please send | | | of this facility to order the above |
| Physician Name: | N | Лedical License #: | Exp. Date: |
| Physician Signature: | | | Date: |
| If any change occurs in the abov | e information (including | authorizations, license info | ormation, and/or authorizing physician) |

a new Prescription Drug Authorization Form must be submitted with applicable licenses before any additional shipments

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may be processed.

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