EVERDIXIE USA
EMS SUPPLY CO.
10101 Foster Avenue • Brooklyn, NY 11236
Toll Free: 800.347.3494 • Fax: 718.257.6401 • www.dixieems.com

PRESCRIPTION DRUG AUTHORIZATION FORM

Dear Customer:

In order to ship prescription pharmaceuticals to you, we must have an authorization from the responsible physician at you place of business or service.

Please have the authorizing physician complete the form below and return this entire letter to us, along with a copy of his/her DEA registration or state license.

If your facility does not have a Medical Director, but is licensed to purchase prescription products, **please send us a copy of the license, along with this letter for identification.**

Customer Number (*optional*): _____

Name of Company: _____

Attn: _____

Address: _____

City & State: _____ Zip: _____

E-mail Address: _____

I hereby authorize internally designated representatives of this facility to order prescription substances.

Please identify _____

❍ Unlimited Authorization

❍ Limited Authorization
(please identify products on separate sheet)

Signature: _____

Physician Name (please print) _____

Choose one:

❍ DEA Registration Number (*copy required)
(For validation purposes only)

_____ Exp. Date _____

❍ State Licensed Number (*copy required)

_____ Exp. Date _____

Date: _____