RX AUTHORIZATION FORM

DermaClip® US, LLC
Phone: (713) 682 - 3185 info@DermaClipUS.com
Phone: (888) 572 - 7200 www.DermaClipUS.com

Date: _____

RX Authorization

For ordering of Legend Devices (items with label/legend stating, “Caution: Federal law restricts this device to sale by or on the order of a physician or an appropriate licensed practitioner”), proper authorization is required from your medical director or the authorized purchaser and/or agent for your department.

Please fill in your institution’s information below and then forward to your authorizing medical representative to have the form completed and returned to DermaClip US, LLC by email (orders@DermaClipUS.com), facsimile (+1-713-572-2255) or mail (730 N. Post Oak Road, Ste. 202, Houston, TX, 77024). Please be sure to include a copy of the referenced license.

In the event of the expiration of the referenced license or a change in physician, medical director, authorized purchaser, and/or agent for your department, a new form must be submitted before orders can be processed.

Customer Information

Facility / Institution Name: _____

Contact Name: _____

Business Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Mobile Number:** _____

Email Address: _____ **Website:** _____

License Information

I, the undersigned, am the Physician, Medical Director, Pharmacist-in-Charge, Physician Assistant or Nurse Practitioner for the above-named facility at the above-specified business address. In this capacity, I hereby authorize the facility to authorize ordering Legend Devices and submit the following referenced license with respect to such orders, with a copy of such license attached to this form.

Name: _____

License or State Board of Pharmacy License #: _____

State: _____ **Expiration Date (mm/dd/yyyy):** _____

Phone Number: _____ **Email Address:** _____

Statement of Authority and Signature

I hereby swear under penalty of perjury that (*i.*) I am the (check one):

☐ **Physician** ☐ **Medical Director** ☐ **Pharmacist-in-Charge** ☐ **PA** ☐ **NP**

with responsibility for the facility identified above in Customer Information with respect to the specified address; (*ii.*) that the license information provided is current and accurate and I am, therefore, licensed to authorize shipment of prescription medical devices to the facility designated; and (*iii.*) I understand that failure to provide complete and truthful information may constitute grounds for the vendor to recommend that appropriate authorities bring disciplinary actions against me.

Name: _____ Signature: _____ Date: ___/____/____