



# RX AUTHORIZATION FORM

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Date: \_\_\_\_\_

## Authorization for Medical Directors and Pharmacists-in-Charge

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 (+1 713-572-2244) 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 or Pharmacist-in-Charge 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

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: \_\_\_/\_\_\_/\_\_\_