



10101 Foster Avenue • Brooklyn, NY 11236  
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# PRESCRIPTION DRUG AUTHORIZATION FORM

Dear Customer:

In order to ship prescription pharmaceuticals to you, we must have an authorization from the responsible physician at your 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)

State Licensed Number (\*copy required)

(For validation purposes only)

# \_\_\_\_\_ Exp. Date \_\_\_\_\_

# \_\_\_\_\_ Exp. Date \_\_\_\_\_

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