

Prescription Authorization Form

Please fill out this form and mail it to Community Medical Supply, 108 Utica Road, Clinton, NY 13323 or fax it to (315) 853-6587.

Account Number _____
Name of company _____ Attention: _____
Address: _____
City _____ State _____ Zip _____
Phone _____ Email Address _____

Dear Community Medical Supply Customer:

In order to sell and ship prescription pharmaceuticals and devices to you, we must receive authorization from the responsible physician at your place of business or service. Please have the authorizing physician complete this form and return it to us.

Thank you,

Community Medical Supply

I hereby authorize the following internally designation representative(s) of this facility to order prescription substances: _____

This is a **limited** **unlimited** authorization
(please circle one)

Physician's signature: _____
Physician's name (please print) _____

Choose one of the following:
DEA Registration Number

_____ Expiration Date _____

Or

State License Number

_____ Expiration Date _____

Today's Date _____