Rx Authorization Form

Customer Name:_____ Contact Name:_____

Shipping Address:_____

City:_____ State:_____ Zip:_____

Phone#_____ Fax#_____

Below must be filled out by Medical Director or Pharmacist-in-Charge of Pharmacy

I am the Medical Director or Pharmacist-in-Charge for the above named Facility. I hereby authorize this Facility to purchase the products specified below to be shipped only to this Facility or to any other entity operated by the Facility at the shipping addresses identified on this authorization.

- Prescription Pharmaceuticals and Devices: Rx Drugs and Rx Devices that are used in EMS applications.

- Limited to these products only: _____

Physician License#, DEA license #, or State board of pharmacy license #

_____

Expiration Date: _____

My signature below indicates that I am the Medical Director or Pharmacist-in-Charge of the Facility named in this Authorization. I further understand that provision of a DEA license number and a copy of the DEA license (for either myself or the Facility) or a Medical License number and a copy of the associated Medical license (collectively or individually the "License") is required. I understand that this Authorization will expire on the same date as the expiration date of the License. I agree to notify EMS Professionals, Inc. prior to the time that I am no longer Medical Director or Pharmacist-in-Charge of the Facility or immediately upon the event the License provided with this Authorization expires or is terminated, surrendered or suspended.

DEA License #, Physician License #, or State Board of Pharmacy License #_____ (To accompany this form)

Signature _____ **Date**

Name _____
(Please Print)

Phone _____

Mail to: **5607 Business 50 West**
Jefferson City, MO 65109

Fax To: **573-635-3129**

Email To: **customerservice@emsprofessionals.net**