

Up to 6 Lines  
of print

**DOCTOR'S NAME(S)**

*Medical Center or Clinic*

Your Building • Your Address

City, State, Zip • Phone

**Doctor(s) Practice**

Dr. Name and Title

Your Form Number and Revision Date

**TAMPER PROOF:** Void Panto • Micro Printing • True Watermark • Security Fibers • Chemical Reactors • Secur Laser

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Label YES NO

**Rx**

One Rx Format

\_\_\_\_\_ M.D. \_\_\_\_\_ M.D.  
Dispense As Written Substitution Permitted

Refill (1) (2) (3) (4) (5) PRN NR DEA No. \_\_\_\_\_