

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

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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. _____