P.O. Box 440 • 1434 Progress Lane
Omro, Wisconsin 54963-0440
Telephone (920) 685-5662 • Fax (800) 541-5967

* 1 DOCTOR / 1 ADDRESS ORDER BLANK*

CALIFORNIA MULTI PRESCRIPTION STANDARD FORMAT PRESCRIPTION FORM

ORDER DATE ________________ DEALER P.O. __________________ CUSTOMER P.O. ___________________

DEALER NAME _____________________________ DEALER #_______ SIGNATURE ___________________

ADDRESS ____

IF REORDER - PREVIOUS JOB #__________ Start Number is Always #000001

STYLE

❒ 1 Part PC4-CAM
❒ 2 Part PC4-CA2M
(Part 2 printed same)

QUANTITY

❒ 10 Pads ❒ 20 Pads ❒ 40 Pads ❒ 60 Pads
❒ 80 Pads ❒ 120 Pads ❒ 240 Pads (Pads of 100)

PRACTICE

☐ **Doctor** *Specialty* Lic. # 00000 DEA # AA00000000
☐ **Doctor** *Specialty* Lic. # 00000 DEA # AA00000000
☐ **Doctor** *Specialty* Lic. # 00000 DEA # AA00000000
☐ **Doctor** *Specialty* Lic. # 00000 DEA # AA00000000
☐ 123 Your Address, Yourtown, USA 00000
(000) 000-0000 Fax (000) 000-0000
☐ 123 Your Address, Yourtown, USA 00000
(000) 000-0000 Fax (000) 000-0000

NAME

ADDRESS

CITY STATE ZIP

D.O.B. GENDER DATE

THIS DOCUMENT CONTAINS VOID PANTOGRAPH, MICROPRINTED SIGN. LINE, REVERSE RX, SECURITY BACKPRINT, THERMOCHROMATIC INK FEATURE, NUMBERING, PRINTED ON SAFETY PAPER

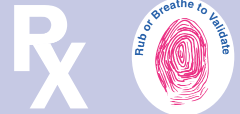
Rx 1	☐ 1-24 ☐ 25-49 ☐ 50-74 ☐ 75-100 ☐ 101-150 ☐ 150 + ☐ Do Not Substitute Refill 0 - 1 - 2 - 3 - 4 - PRN Units ________
Rx 2	☐ 1-24 ☐ 25-49 ☐ 50-74 ☐ 75-100 ☐ 101-150 ☐ 150 + ☐ Do Not Substitute Refill 0 - 1 - 2 - 3 - 4 - PRN Units ________
Rx 3	☐ 1-24 ☐ 25-49 ☐ 50-74 ☐ 75-100 ☐ 101-150 ☐ 150 + ☐ Do Not Substitute Refill 0 - 1 - 2 - 3 - 4 - PRN Units ________

Prescription is void if the number of drugs prescribed is not noted. ______ Void after ________________

☐ Spanish SP01

06080112345 #000001

Signature ____________________



COMPLETE INFORMATION & DEA CERTIFICATE IS REQUIRED BEFORE ORDER WILL BE ENTERED.

PRACTICE NAME ____

PHYSICIAN NAME ____

SPECIALTY____ ☐ Do Not Print On Form

ADDRESS (No P.O. Box Allowed)____

CITY ____ STATE CA ZIP ___________

PHONE ___________________________ FAX ___________________________

DEA # _____________________ LICENSE # _____________________

PHYSICIANS SIGNATURE____________________________________ (Or Authorized Employee)

☐ Please provide proof
☐ Mail ☐ Fax ___________________
☐ Email ___________________

ADDITIONAL CHARGE OPTIONS

☐ Pad in 50's
☐ Padded Wraparound Cover ☐ Stapled Wraparound Cover