

DEALER # \_\_\_\_\_

DEALER NAME \_\_\_\_\_

DEALER P.O. \_\_\_\_\_

CUSTOMER P.O. \_\_\_\_\_

ORDER DATE \_\_\_\_\_ IF REORDER - PREV. JOB # \_\_\_\_\_  PROOF REQUESTED

**\* ORDER BLANK\***

**KENTUCKY STANDARD FORMAT  
PRESCRIPTION FORM**

**STANDARD FORMAT KENTUCKY PRESCRIPTION FORMS**

**Standard Security Features:** Void Pantograph, Security Backprinting, Reverse Rx on Top Right Corner.

STYLE

- 1 Part PC4-KY (Pads of 100)
- 2 Part PC4-KY2 (Pads of 100)  
(Second Part Blank)

QUANTITY

- 10 Pads
- 20 Pads
- 40 Pads
- 60 Pads
- 80 Pads
- 120 Pads
- 240 Pads

**NAME**  
Address  
CITY, STATE, ZIP  
PHONE  
LIC. # 00000000 DEA # \_\_\_\_\_

Rx

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Name \_\_\_\_\_

Address \_\_\_\_\_ Date \_\_\_\_\_

1-24  
 25-49  
 50-74  
 75-100  
 101-150  
 151 and over

Refill NR 1 2 3 4 5 \_\_\_\_\_

Prescription is void if more than one (1) prescription is written per blank.

(Size 5-1/2" x 4-1/4") Base Copy Pantone Green - Imprint Information Black

\*PRACTICE NAME \_\_\_\_\_

\*PHYSICIAN NAME \_\_\_\_\_

SPECIALTY \_\_\_\_\_

\*ADDRESS \_\_\_\_\_

\*CITY \_\_\_\_\_ \*STATE \_\_\_\_\_ \*ZIP \_\_\_\_\_

PHONE \_\_\_\_\_

DEA # \_\_\_\_\_ \*LICENSE # \_\_\_\_\_

PHYSICIANS SIGNATURE \_\_\_\_\_ (Or Authorized Employee)

\*Required Fields

**COMPLETE INFORMATION REQUIRED BEFORE ORDER WILL BE ENTERED.**

**Optional Features Available at Additional Charge.**

Padding in 50's, drilling of part 2, backprinting part 1 or part 2  
and print face part 2, stapled wraparound cover.