



*** 1 DOCTOR - ORDER BLANK ***
CALIFORNIA STANDARD FORMAT
PRESCRIPTION FORM

Start # is Always #000001

IF REORDER - PREV. JOB # _____ PROOF REQUESTED

ORDER DATE _____ DEALER P.O. _____ CUSTOMER P.O. _____

DEALER NAME _____ DEALER # _____ SIGNATURE _____

ADDRESS _____

SHIPPING INFORMATION: _____

STYLE

1 Part PC4-CA

8 Pads 16 Pads

24 Pads 32 Pads

40 Pads 48 Pads

64 Pads 80 Pads

2 Part PC4-CA2

8 Pads 16 Pads



24 Pads 32 Pads

80 Pads 120 Pads

160 Pads 256 Pads

Optional Copy

Spanish Label

FAMILY PRACTICE CENTER		000001
Physician Name, M.D.		19301102214
123 Address Way City, ST 12345 123-456-1234 Fax 123-456-5678		LIC.# X12345 DEA# XX1234567 NPI# X123456
SECURITY FEATURES LISTED ON BACK		
PATIENT NAME	DOB	GENDER
ADDRESS		PH. NO.
 Serial# WCZZ98A00001	Quantity <input type="checkbox"/> 1-24 <input type="checkbox"/> 25-49 <input type="checkbox"/> 50-74 <input type="checkbox"/> 75-100 <input type="checkbox"/> 101-150 <input type="checkbox"/> 151 and over	
	Unit _____ Refills: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Do Not Substitute	
<input type="checkbox"/> SPANISH LABEL		
Signature _____ Date _____ <small>Prescription is void if the number of drugs prescribed is not noted. Number of Drugs _____</small> SP 98		<small>RUB RED IMAGE</small>  <small>FADES WITH HEAT</small>
<small>BLUE BACKGROUND, REFLECTIVE WATERMARK ON BACK. SECURITY FEATURES LISTED ON BACK.</small>		

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

MAXIMUM OF 5 LINES

PRACTICE NAME _____

PHYSICIAN NAME _____

SPECIALTY _____ Do Not Print On Form

ADDRESS (No P.O. Box Allowed) _____

CITY _____ STATE **CA** ZIP _____

PHONE _____ FAX _____

DEA # _____ LICENSE # _____ NPI # _____

PHYSICIANS SIGNATURE _____ (Or Authorized Employee)

Please provide proof

Email _____

ADDITIONAL CHARGE OPTIONS

Imprint Part 2 Pad in 50's

Padded Wraparound Cover



***MULTI DOCTOR / MULTI ADDRESS
ORDER BLANK ***

**CALIFORNIA STANDARD FORMAT
PRESCRIPTION FORM**

ORDER DATE _____ DEALER P.O. _____ CUSTOMER P.O. _____

DEALER NAME _____ DEALER # _____ SIGNATURE _____

ADDRESS _____

IF REORDER - PREVIOUS JOB # _____ PROOF REQUESTED Start Number is Always #000001

- | | |
|---|---|
| <input type="checkbox"/> 1 Part PC4-CA | <input type="checkbox"/> 2 Part PC4-CA2 |
| <input type="checkbox"/> 8 Pads <input type="checkbox"/> 16 Pads | <input type="checkbox"/> 8 Pads <input type="checkbox"/> 16 Pads |
| <input type="checkbox"/> 24 Pads <input type="checkbox"/> 32 Pads | <input type="checkbox"/> 24 Pads <input type="checkbox"/> 32 Pads |
| <input type="checkbox"/> 40 Pads <input type="checkbox"/> 48 Pads | <input type="checkbox"/> 80 Pads <input type="checkbox"/> 120 Pads |
| <input type="checkbox"/> 64 Pads <input type="checkbox"/> 80 Pads | <input type="checkbox"/> 160 Pads <input type="checkbox"/> 256 Pads |

SHIPPING INFORMATION:

Optional Copy

Spanish Label

PHYSICIANS SIGNATURE (Or Authorized Employee)

PRACTICE NAME _____

DOC. 1 _____ SPECIALTY _____ Do Not Print On Form

DEA # _____ LICENSE # _____ NPI # _____

DOC. 2 _____ SPECIALTY _____ Do Not Print On Form

DEA # _____ LICENSE # _____ NPI # _____

DOC. 3 _____ SPECIALTY _____ Do Not Print On Form

DEA # _____ LICENSE # _____ NPI # _____

DOC. 4 _____ SPECIALTY _____ Do Not Print On Form

DEA # _____ LICENSE # _____ NPI # _____

ADDRESS 1 _____

CITY 1 _____ STATE 1 **CA** ZIP 1 _____

PHONE 1 _____ FAX 1 _____

ADDRESS 2 _____

CITY 2 _____ STATE 2 **CA** ZIP 2 _____

PHONE 2 _____ FAX 2 _____

ADDRESS 3 _____

CITY 3 _____ STATE 3 **CA** ZIP 3 _____

PHONE 3 _____ FAX 3 _____

ADDRESS 4 _____

CITY 4 _____ STATE 4 **CA** ZIP 4 _____

PHONE 4 _____ FAX 4 _____

Please provide proof

OPTIONS

Imprint Part 2 Pad in 50's

Padded Wraparound Cover

Email _____

MAXIMUM OF 5 LINES