



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

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-FL
8 Pads 16 Pads
24 Pads 32 Pads
40 Pads 48 Pads
64 Pads 80 Pads
2 Part PC4-FL2
8 Pads 16 Pads
24 Pads 32 Pads
80 Pads 120 Pads
160 Pads 256 Pads

Optional Copy

- DOB M/F Spanish

Form for Family Practice Center with fields for Patient Name, Address, Date, Refill, and a 'PLUS PPD IMAGE' logo.

COMPLETE INFORMATION IS REQUIRED BEFORE ORDER WILL BE ENTERED.

PRACTICE NAME _____
PHYSICIAN NAME _____
SPECIALTY _____
ADDRESS (No P.O. Box Allowed) _____
CITY _____ STATE FL ZIP _____
PHONE _____ FAX _____
DEA # _____ LICENSE # _____ NPI # _____
PHYSICIANS SIGNATURE _____ (Or Authorized Employee)

Please provide proof

ADDITIONAL CHARGE OPTIONS

Start Number

- Imprint Part 2 Pad in 50's Numbering
Padded Wraparound Cover Stapled Wraparound Cover

Email _____



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

**FLORIDA STANDARD FORMAT
PRESCRIPTION FORM**

IF REORDER - PREVIOUS JOB # _____ Proof Requested

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

DEALER NAME _____ DEALER # _____ SIGNATURE _____

ADDRESS _____

- | | |
|---|---|
| <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

- DOB M/F Spanish Label

PRACTICE NAME _____

DOC. 1 _____ SPECIALTY _____

DEA # _____ LICENSE # _____ NPI # _____

DOC. 2 _____ SPECIALTY _____

DEA # _____ LICENSE # _____ NPI # _____

DOC. 3 _____ SPECIALTY _____

DEA # _____ LICENSE # _____ NPI # _____

DOC. 4 _____ SPECIALTY _____

DEA # _____ LICENSE # _____ NPI # _____

ADDRESS 1 _____

CITY 1 _____ STATE 1 **FL** ZIP 1 _____

PHONE 1 _____ FAX 1 _____

ADDRESS 2 _____

CITY 2 _____ STATE 2 **FL** ZIP 2 _____

PHONE 2 _____ FAX 2 _____

ADDRESS 3 _____

CITY 3 _____ STATE 3 **FL** ZIP 3 _____

PHONE 3 _____ FAX 3 _____

ADDRESS 4 _____

CITY 4 _____ STATE 4 **FL** ZIP 4 _____

PHONE 4 _____ FAX 4 _____

Please provide proof

ADDITIONAL CHARGE OPTIONS

Start Number

Imprint Part 2 Pad in 50's Numbering _____

Padded Wraparound Cover

Email _____

MAXIMUM OF 5 LINES