



* 1 DOCTOR - ORDER BLANK *
KENTUCKY 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-KY

- 8 Pads, 16 Pads, 24 Pads, 32 Pads, 40 Pads, 48 Pads, 64 Pads, 80 Pads

2 Part PC4-KY2

- 8 Pads, 16 Pads, 24 Pads, 32 Pads, 80 Pads, 120 Pads, 160 Pads, 256 Pads

Optional Copy

- DOB, M/F, Spanish

Practice Name Prints Here
Doctors Name1
234 Research Avenue1
Any City1, KY1 23456
(999) 999-9999
Fax 111-222-1234
Lic # L12345
DEA # D12345
NPI # N12345
PATIENT NAME _____ DATE _____
ADDRESS _____
Initial Quantity
1-24, 25-49, 50-74, 75-100, 101-150, 151 and over
Refill NR 1 2 3 4 5
Signature _____
Prescription is void if more than one (1) prescription is written per blank.
GREEN BACKGROUND, REFLECTIVE WATERMARK ON BACK, SECURITY FEATURES LISTED ON BACK.

COMPLETE INFORMATION IS REQUIRED BEFORE ORDER WILL BE ENTERED.

PRACTICE NAME _____

PHYSICIAN NAME _____

SPECIALTY _____

ADDRESS (No P.O. Box Allowed) _____

CITY _____ STATE KY 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 ***

**KENTUCKY STANDARD FORMAT
PRESCRIPTION FORM**

IF REORDER - PREVIOUS JOB # _____ Proof Requested

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

DEALER NAME _____ DEALER # _____ SIGNATURE _____

ADDRESS _____

- 1 Part PC4-KY** **2 Part PC4-KY2**
- 8 Pads 16 Pads 8 Pads 16 Pads
- 24 Pads 32 Pads 24 Pads 32 Pads
- 40 Pads 48 Pads 80 Pads 120 Pads
- 64 Pads 80 Pads 160 Pads 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 **KY** ZIP 1 _____

PHONE 1 _____ FAX 1 _____

ADDRESS 2 _____

CITY 2 _____ STATE 2 **KY** ZIP 2 _____

PHONE 2 _____ FAX 2 _____

ADDRESS 3 _____

CITY 3 _____ STATE 3 **KY** ZIP 3 _____

PHONE 3 _____ FAX 3 _____

ADDRESS 4 _____

CITY 4 _____ STATE 4 **KY** 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