

*** 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#
- ☐ 2 Part PC4-CA2#
(Second Part Blank)

QUANTITY

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

Optional Copy

- ☐ DOB
- ☐ M/F
- ☐ Spanish

JOHN SMITH, M.D. <i>Specialty</i> 123 Your Address YOURTOWN, USA 00000 (000) 000-0000		
PRI040225123456	Lic. # 12345 DEA # MA00000000	
<small>DOCUMENT CONTAINS VOID PANTOGRAPH, MICROPRINTED SIGN. LINE, REVERSE RX, SECURITY BACKPRINT THERMOCHROMATIC INK FEATURE, NUMBERING, CHEMICAL REACTIVE SAFETY PAPER</small>		
<div style="display: flex; justify-content: space-between;"><div>Name _____</div><div>Date _____</div></div>		
<div style="display: flex; justify-content: space-between;"><div>Address _____</div><div style="text-align: right;"><div style="display: flex; align-items: center;"><div style="flex: 1;"><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</div><div style="text-align: right; padding-left: 10px;">Units</div></div></div></div>		
<div style="display: flex; justify-content: space-between;"><div>Refill <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5</div><div>Signature _____</div></div>		
<div style="display: flex; justify-content: space-between;"><div>Void after _____ <input type="checkbox"/> Do Not Substitute-Dispense As Written</div><div>SP01 _____</div></div>		
<small>Prescription is void if the number of drugs prescribed is not noted.</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 # _____

PHYSICIANS SIGNATURE _____ (Or Authorized Employee)

☐ Please provide proof

- ☐ Mail ☐ Fax _____
- ☐ Email _____

ADDITIONAL CHARGE OPTIONS

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

STYLE ☐ 1 Part PC4-CA# ☐ 2 Part PC4-CA2#
(Second Part Blank)

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

Optional Copy

☐ DOB ☐ M/F ☐ Spanish

PHYSICIANS SIGNATURE (Or Authorized Employee)

SHIPPING INFORMATION:

PRACTICE NAME _____

DOC. 1 _____ SPECIALTY _____ ☐ Do Not Print On Form

DEA # _____ LICENSE # _____

DOC. 2 _____ SPECIALTY _____ ☐ Do Not Print On Form

DEA # _____ LICENSE # _____

DOC. 3 _____ SPECIALTY _____ ☐ Do Not Print On Form

DEA # _____ LICENSE # _____

DOC. 4 _____ SPECIALTY _____ ☐ Do Not Print On Form

DEA # _____ LICENSE # _____

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

☐ Mail ☐ Fax _____

☐ Email _____

OPTIONS

☐ Imprint Part 2 ☐ Pad in 50's

☐ Padded Wraparound Cover ☐ Stapled Wraparound Cover

MAXIMUM OF 5 LINES