

# MEDICAL CENTER & HEALTHCARE CLINIC

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## MEDICAL PRESCRIPTION

**Prescription ID:** #46  
**Date:** May 22, 2025  
**Patient Name:**  
**Patient ID:** #33  
**Doctor:** Dr.

## PRESCRIBED MEDICATIONS

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Dr.  
Physician Signature

This prescription is valid for 30 days from the date of issue. Please present this document to your pharmacist. Contact your doctor for any clarifications.