Prescription Drug Authorization Form

Please fill out this form and mail to: **Medical Shipment LLC, 70 Lively Blvd., Elk Grove Village, IL 60007-1619**
Or fax to 847.506.0524

Account Number: _____

Company Name: _____

Attn: _____

Address: _____

City and State: _____**Zip:** _____

Phone: _____**E-mail** : _____

Dear Medical Shipment Customer:

In order to sell and ship prescription pharmaceuticals to you, we must receive authorization from the responsible physician at your place of business or service.

Please have the authorizing physician complete this form and return it to us, along with a copy of his/her DEA registration or state license.

We can only ship to the state in which the physician is licensed in. If your facility does not have a Medical Director, but is licensed to purchase prescription products, please send us a copy of the license along with this letter for identification.

Thank you,
Medical Shipment

I hereby authorize the following internally designated representative(s) of this facility to order prescription substances.
(Please identify here)_____
_____

☐ Unlimited Authorization

☐ Limited Authorization
(list specific items on separate sheet)

Physician's Signature: _____
Physician's Name (Please Print) _____

Choose one:

DEA Registration Number* ☐
(For validation purposes only) *Copy Required
#_____ Exp._____

State License Number * ☐
*Copy Required
#_____ Exp._____

Date: _____

MEDICAL·SHIPMENT
Nursing Education Supply Experts, At Your Service

70 Lively Boulevard Elk Grove Village IL 60007-1619
Ph: 847.253.3000 Fax: 847-506-0524
www.medicalshipment.com

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Limited Authorization

ITEM #	PRODUCT NAME

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