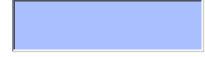


# PRESCRIPTION PAD ORDER FORM



Order Type                      New                      Repeat with Change                      Exact

Customer Name

Address

Account Number

Phone Number

Fax Number

**Prescriber Information (as it will appear on form)** \* Required Field

Clinic or Business Name

\*Prescriber Name

Specialty

\*Address  \*Ste

\*City  \*State  \*Zip

\*Phone #

\*License #  DEA #

NPI #  IF STATE REQUIRED, INCLUDE DEA #

Method of Payment  Check  Cash  PO  Credit Card

SHIP-TO:  Click here if same as above. (A California address must be on file under the prescribers CA License # or DEA#)

Business/Prescriber Name

\*Address  \*Ste

\*City  \*State  \*Zip

**For CA, DE, FL, GA, IN, KY, ME, WA, WV, WY -**      Yes

**Is authorized contact person same as above Prescriber?**      If No, Include Name

Form Number / Order Quantity    Form Number       **Proof?**      YES      NO

One Part Pads	CA One Pt Pads**	Two Part Books
4 Pads		9 Books *
8 Pads	8 Pads	18 Books
12 Pads	16 Pads	27 Books
16 Pads	24 Pads	36 Books
20 Pads	32 Pads	45 Books
40 Pads	40 Pads	81 Books
60 Pads	56 Pads	117 Books
80 Pads	80 Pads	162 Books

**Enter Additional Prescribers on Page 2**

Total # of Prescribers

Total # of Addresses

**Design**

1 part Pads (100 forms per pad)  
2 part Books (50 sets per book, wraparound cover, printed on part 2)

**Security Features**

-Void Pantograph	- ThermoChromic Ink
- Reverse Rx	- Microprint Line
-Batch Numbers, if specified	- Watermark on Back
-Preprinted prescriber information	- Chemical Protection Paper
-Blue or Green background on white paper	

**SECURE PADS/BOOKS**  
\*4 pads/ 9 books minimum order  
All orders must be in multiple of 4 pads or 9 books  
\*\*Numbered pads must be ordered in multiples of 8

**PLAIN BOND PADS**  
8 pads minimum order. All orders must be in multiple of 4 pads.

TEL: (800) 494 - 5637  
FAX: (800) 553 - 4849  
EMAIL: [wcs@4wilmer.com](mailto:wcs@4wilmer.com)

# ADDITIONAL PRESCRIBERS

## Additional Prescribers (as it will appear on form)

\* Required Field

<b>Clinic or Business Name</b>	<input type="text"/>				
<b>*Prescriber Name</b>	<input type="text"/>				
<b>Specialty</b>	<input type="text"/>				
<b>*Address</b>	<input type="text"/>	<b>*Ste</b>	<input type="text"/>		
<b>*City</b>	<input type="text"/>	<b>*State</b>	<input type="text"/>	<b>*Zip</b>	<input type="text"/>
<b>*Phone #</b>	<input type="text"/>				
<b>*License #</b>	<input type="text"/>	<b>DEA #</b>	<input type="text"/>		
<b>NPI #</b>	<input type="text"/>	IF STATE REQUIRED, INCLUDE DEA #			

<b>Clinic or Business Name</b>	<input type="text"/>				
<b>*Prescriber Name</b>	<input type="text"/>				
<b>Specialty</b>	<input type="text"/>				
<b>*Address</b>	<input type="text"/>	<b>*Ste</b>	<input type="text"/>		
<b>*City</b>	<input type="text"/>	<b>*State</b>	<input type="text"/>	<b>*Zip</b>	<input type="text"/>
<b>*Phone #</b>	<input type="text"/>				
<b>*License #</b>	<input type="text"/>	<b>DEA #</b>	<input type="text"/>		
<b>NPI #</b>	<input type="text"/>	IF STATE REQUIRED, INCLUDE DEA #			

<b>Clinic or Business Name</b>	<input type="text"/>				
<b>*Prescriber Name</b>	<input type="text"/>				
<b>Specialty</b>	<input type="text"/>				
<b>*Address</b>	<input type="text"/>	<b>*Ste</b>	<input type="text"/>		
<b>*City</b>	<input type="text"/>	<b>*State</b>	<input type="text"/>	<b>*Zip</b>	<input type="text"/>
<b>*Phone #</b>	<input type="text"/>				
<b>*License #</b>	<input type="text"/>	<b>DEA #</b>	<input type="text"/>		
<b>NPI #</b>	<input type="text"/>	IF STATE REQUIRED, INCLUDE DEA #			