PRESCRIPTION PAD ORDER FORM

CLEAR

SAVE

PRINT

EMAIL

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 #**

IF STATE REQUIRED, INCLUDE DEA #

NPI #

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 -
Is authorized contact person same as above Prescriber? ☐ Yes ☐ 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

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.

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

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

ADDITIONAL PRESCRIBERS

Additional Prescribers (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 #	

Clinic or Business Name					
*Prescriber Name					
Specialty					
*Address				*Ste	
*City		*State		*Zip	
*Phone #					
*License #		DEA #			
NPI #				IF STATE REQUIRED, INCLUDE DEA #	

Clinic or Business Name					
*Prescriber Name					
Specialty					
*Address				*Ste	
*City		*State		*Zip	
*Phone #					
*License #		DEA #			
NPI #				IF STATE REQUIRED, INCLUDE DEA #	

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