

The physician is to fill out all required areas of this form. The Credit Card information is generally that of the patient. All orders will be shipped to your office "care of" the patient designated in the Credit Card information.

Place Physician's office stamp, or photocopy letterhead, in the space provided:

Choose your dispensing pharmacy:

Choose the country or countries below that you will allow us to dispense your medication from licensed Pharmacies. Based on your decision our website will choose where to send your prescriptions based on product availability and/or price.

- Canada
 New Zealand
 European Union
 Australia
 Chile
 All

Credit Card Holder Information: (Please Print Clearly) – Section B

Name on Card:	Type of Card (Visa/MasterCard):
Credit Card Number:	Expiration Date (month/year):
Signature:	

Physician Information: (Please Print Clearly) – Section C

First Name:	State:
Last Name:	Zip:
Street 1:	Phone: () -
City:	Fax: () -
DEA #	License #

Prescriptions (Please Print Clearly) – Section D - Please note that we will only send a maximum of 3 months supply per medication order. Refills are allowed. We can only allow refills for up to 1 year for each medication. If available, we will substitute a generic drug unless brand name drug is specified. Physicians please attach prescriptions or complete Section D.

Medications (Please Print Clearly)	Strength	Quantity	Signature	Generic Allowed?	# Refills
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Physician's Signature: _____ Date: _____