

DELAWARE

PRESCRIPTION PADS & LASER FORMS

Benefits:

- Easy to order
- Fast Delivery
- Available in many different styles and sizes
- Color changing ink is used, which is an easy way for pharmacists to check for authenticity
- Secure shipment process
- Includes all state of Delaware required features
- Padded forms available in 1 or 2 part
- Laser Forms - Blank, Numbered or Imprinted

Imprinted or Blank
8-1/2" x 11"

Additional features include: (optional)

- Custom backprinting
- 1 Part Form padded in 100's
- Drilling on part 2
- 2 Part Form padded in 50's

Standard 5-1/2" x 4-1/4"
Landscape or Portrait

Doctor1 Specialty Lic. # 12345 DEA # MA0000000
 Doctor2 Specialty Lic. # 12345 DEA # MA0000000
 Doctor3 Specialty Lic. # 12345 DEA # MA0000000
 Address1, City, DE 00000 (000) 000-0000 Fax (000) 000-0000
 Address2, City, DE 00000 (000) 000-0000 Fax (000) 000-0000
 Address3, City, DE 00000 (000) 000-0000 Fax (000) 000-0000

Name _____ DOB _____
 Address _____

HOMETOWN CLINIC
 John Doe, M.D.
 Family Practice
 1234 Your Address
 Your City, DE 98765 Lic. #: A12345
 (987) 654-3210 DEA #: AA7894321
 Fax (987) 654-3211 NPI #: 789456123

#00001

Name _____ DOB _____
 Address _____ Date _____ MF _____

Spanish
 Refill NR 1 2 3 4 5
 Void After _____

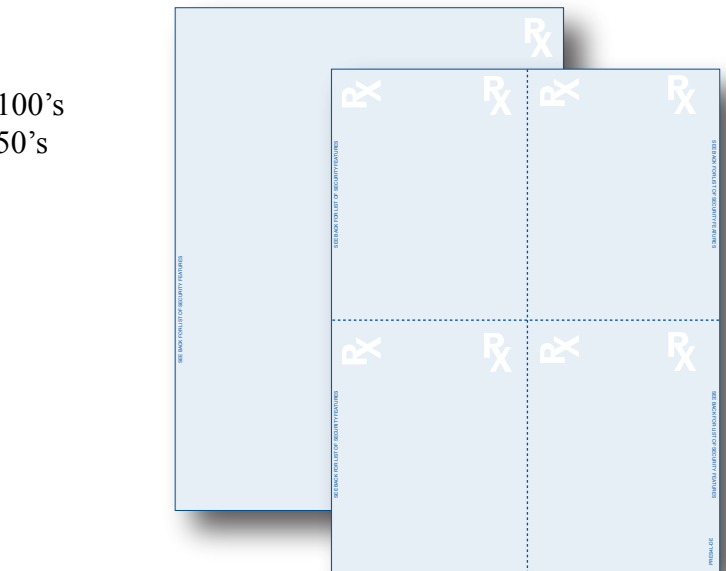
Substi _____
 Presc _____

1-24
 25-49
 50-74
 75-100
 101-150
 151 and over
 _____ Units

Spanish
 Refill NR 1 2 3 4 5
 Void After _____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" in the space below.

Substitution Permitted _____
 Prescription is void if more than one (1) controlled substance is written per blank.



Doctor1 Specialty Lic. # 12345 DEA # MA0000000
 Doctor2 Specialty Lic. # 12345 DEA # MA0000000
 Doctor3 Specialty Lic. # 12345 DEA # MA0000000
 Address1, City, DE 00000 (000) 000-0000 Fax (000) 000-0000
 Address2, City, DE 00000 (000) 000-0000 Fax (000) 000-0000
 Address3, City, DE 00000 (000) 000-0000 Fax (000) 000-0000

Name _____ DOB _____
 Address _____

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