

NEW JERSEY

PRESCRIPTION PADS & LASER FORMS

Benefits:

- Easy to order
- Fast Delivery
- Secure shipment process
- Includes all state of New Jersey required features
- Padded forms available in 1 or 2 part
- Laser Forms - 1up

Standard Laser Styles
Imprinted Only 8-1/2" x 11"

Top Left • Top Center • Center Center

Additional features include: (optional)

- Printing on part 2 available
- Custom backprinting
- Padding in 50's (standard padding - 100's)
- Drilling on part 2

Standard 4" x 5-1/2"

State of New Jersey
PRESCRIPTION BLANK

PRACTICE NAME
DOCTOR
SPECIALTY
STREET
CITY STATE ZIP
PHONE

NPI # _____
DEA # _____
IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER ON REVERSE SIDE

PATIENT _____ D.O.B. _____
ADDRESS _____ DATE _____

DO NOT REPEAT _____ SIGNATURE OF PRESCRIBER _____
REFILL _____ TIMES

Use a separate form for each controlled substance prescription
THEY, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY LAW

State of New Jersey
PRESCRIPTION BLANK

NAME OF INSTITUTION OR FACILITY
ADDRESS
CITY STATE ZIP PHONE

HEALTHCARE FACILITY

State of New Jersey
PRESCRIPTION BLANK

NAME OF PRACTICE
NAME AND ACADEMIC DEGREE
IDENTIFICATION OF PRACTICE, PRACTICE OR SPECIALTY
STREET
CITY STATE ZIP PHONE

OPTOMETRIST TPA CERTIFIED

State of New Jersey
PRESCRIPTION BLANK

PRACTICE NAME
DOCTOR
SPECIALTY
STREET
CITY STATE ZIP PHONE

Standard Laser Styles
Imprinted Only 8-1/2" x 11"

State of New Jersey
PRESCRIPTION BLANK

NAME AND TITLE
STREET
CITY STATE ZIP PHONE

NURSE PRACTITIONER/CLINICAL

State of New Jersey
PRESCRIPTION BLANK

NAME AND TITLE
STREET
CITY STATE ZIP PHONE

CERTIFIED NURSE MIDWIFE

State of New Jersey
PRESCRIPTION BLANK

NAME OF PRACTICE
NAME AND ACADEMIC DEGREE
IDENTIFICATION OF PRACTICE, PRACTICE OR SPECIALTY
STREET
CITY STATE ZIP PHONE

PRESCRIBING EYEWEAR

State of New Jersey
PRESCRIPTION BLANK

NAME AND TITLE OF PHYSICIAN ASSISTANT
STREET
CITY STATE ZIP PHONE

PHYSICIAN ASSISTANT

MD, DDS, DMD, DPM, DVM

Sequential Numbering • Green Void Pantograph • Blue Security Backprinting • Seven Standard Formats
Bar Coded • State Mandated Formats • Thermocromatic Ink Rx • Microprint
Approved Manufacturer



Product Code	Parts	Forms/Pad	5 Pads	10 Pads	20 Pads	40 Pads	60 Pads	80 Pads	120 Pads	
#1, #2 Standard Pads										Price/Pad
<input type="checkbox"/> PC4___-NJ14	1	100	22.20	13.00	9.80	7.20	6.50	6.20	5.90	
<input type="checkbox"/> PC4___-NJ214	2	100	30.50	17.90	13.70	10.20	10.00	9.50	9.20	
<input type="checkbox"/> #1 MD, DDS, DMD, DPM, DVM <input type="checkbox"/> #2 HEALTHCARE FACILITY										
#3, #4, #5, #6, #8 Standard Pads										Price/Pad
<input type="checkbox"/> PC4___-NJ14	1	100	22.70	14.00	11.30	8.80	8.20	8.00	7.70	
<input type="checkbox"/> PC4___-NJ214	2	100	33.50	21.40	18.00	15.40	14.90	14.50	13.90	
<input type="checkbox"/> #3 OPTOMETRIST TPA CERTIFIED <input type="checkbox"/> #6 PRESCRIBING EYEWEAR <input type="checkbox"/> #4 NURSE PRACTITIONER/CLINICAL <input type="checkbox"/> #8 PHYSICIAN ASSISTANT <input type="checkbox"/> #5 CERTIFIED NURSE MIDWIFE										
Laser			1000	2000	4000	6000	8000	10000		Price/M
<input type="checkbox"/> PC41Z-NJ14	1	Imprinted Top Left	209.00	170.00	151.00	147.00	144.00	140.00	140.00	
<input type="checkbox"/> PC4_Z-NJ14	1	Imprinted Top Left	368.00	299.00	200.00	158.00	150.00	145.00	145.00	
<input type="checkbox"/> PC41Z-NJ14TC (Doctor)	1	Imprinted Top Center	209.00	170.00	151.00	147.00	144.00	140.00	140.00	
<input type="checkbox"/> PC42Z-NJ14TC (Facility)	1	Imprinted Top Center	209.00	170.00	151.00	147.00	144.00	140.00	140.00	
<input type="checkbox"/> PC41Z-NJ14CC (Doctor)	1	Imprinted Center Center	209.00	170.00	151.00	147.00	144.00	140.00	140.00	

Style: Portrait Only

Parts: 1 Part 2 Part

Quantity: 5 Pads 10 Pads
 20 Pads 40 Pads
 60 Pads 80 Pads
 120 Pads

Laser Quantity:

Imprinted 1000 2000 4000 6000 8000 10000

Responsible Prescriber: _____

Start Number: #000001 _____ (Unless same prescriber orders multiple forms in the same month.)

Purchase Order # (if required) _____

Please send me your catalog

*** FAX ORDER FORM***

Practice Information

Practice: _____

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

License #: _____ DEA #: _____

NPI #: _____

Specialty: _____ Phone #: _____

Shipping address if different than above

Address: _____

Physician's Signature _____ (Required)

Supervising Physician _____

License # _____ Phone # _____

Address (if different from above) _____