



2923 Saturn St., Suite D • Brea, CA 92821
 ph: 714-256-9543 • fax: 714-256-0975
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LONG FORMAT - 8.5”(w) x 3.667”(h)

<h1>PRACTITIONER INFO IMPRINTED HERE</h1>							NAME				
							DOB		GENDER		
							ADDRESS				
							DATE		PHONE		
Rx	1-24	25-49	50-74	75-100	101-150	151+	MED. / SIG.	mg or %sol.	No. or cc.	Refill (circle one)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				0 1 2 3 4 5	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				0 1 2 3 4 5	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				0 1 2 3 4 5	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				0 1 2 3 4 5	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				0 1 2 3 4 5	
RESERVED FOR PRACTITIONER'S STAMP SP 04							# of Drugs Prescribed: _____ <input type="checkbox"/> DO NOT SUBSTITUTE (Initials: _____) <input type="checkbox"/> Label in Spanish			RUB SEAL BRISKLY TO CHANGE COLOR	
PRESCRIBING PRACTITIONER'S SIGNATURE: _____ Document is printed using Security Features to insure authenticity: Document will indicate VOID if scanned or photocopied. To view watermark on reverse side of document hold at an angle. Seal located in lower right-hand corner of the front will change color when rubbed briskly. Entire document will indicate an obvious change in appearance if attempted to alter by chemical means. "Prescription is VOID if the number of drugs prescribed is not noted."											

SHORT FORMAT - 5.5”(w) x 4.25”(h)

<h1>PRACTITIONER INFO IMPRINTED HERE</h1>										
Rx										
PATIENT NAME			DOB		GENDER					
ADDRESS			PHONE		DATE					
1-24	25-49	50-74	75-100	101-150	151+	MED / SIG	mg or %sol.	No. or cc.	Refill	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	
PRESCRIBING PRACTITIONER'S SIGNATURE: _____ Document is printed using Security Features to insure authenticity: Document will indicate VOID if scanned or photocopied. To view watermark on reverse side of document hold at an angle. Seal located in lower right-hand corner of the front will change color when rubbed briskly. Entire document will indicate an obvious change in appearance if attempted to alter by chemical means. "Prescription is VOID if the number of drugs prescribed is not noted."										
SP 04							RUB SEAL BRISKLY TO CHANGE COLOR			

2 PART FORMS ALSO AVAILABLE. (INCLUDES "PRINTED" 2ND SHEET BLACK & WHITE REPRODUCTION OF SECURE TOP SHEET / FOR RECORD KEEPING PURPOSES ONLY).



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CA Rx PRICING

(PLEASE CALL FOR GREATER QUANTITIES - SUBJECT TO CHANGE)

SINGLE PAGE FORM: (PADS OF 50)	
QUANTITY (SCRIPTS)	PRICE*
60 (3 PADS OF 20)	\$50.00
300	\$180.00
600	\$200.00
1200	\$230.00
1800	\$260.00
2400	\$290.00
3000	\$320.00
3600	\$360.00
4800	\$420.00
6000	\$480.00

2 PART FORM: (PADS OF 50)	
QUANTITY (SCRIPTS)	PRICE*
60 (3 PADS OF 20)	\$65.00
300	\$200.00
600	\$240.00
1200	\$300.00
1800	\$350.00
2400	\$410.00
3000	\$460.00
3600	\$520.00
4800	\$640.00
6000	\$760.00

* Imprinting To The Backside Of The Script Can Be Done For An Additional Fee Of \$50.00. Logos Can Be Imprinted In Black & White (Design Charges May Apply). Shipping Additional - UPS Ground (Overnight Shipping Extra).

ORDER FORM

QUANTITY: _____
 SIZE: LONG SHORT
 TYPE: SINGLE 2 PART

Medical Firm/Clinic Name (If Applicable): _____

Primary Contact (If Applicable): _____

Street Address _____ City _____ Zip Code _____

Phone #: _____ Fax #: _____

Practitioner's Name(s), _____ CA License #* _____ DEA #* _____
 (List In Order If More Than One):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Payment Info: Credit Card: Visa Mastercard Amex Discover (Circle One Please)

CC#: _____ Exp. Date: _____ SC#: _____

Check #: _____ D/L #: _____ Exp. Date: _____

(Please Read & Sign Before Returning): Accepted By: **X** _____ Date: _____

* LEGIBLE COPIES OF ALL PRACTITIONER'S CALIFORNIA STATE LICENSE & DEA CERTIFICATES ARE REQUIRED BY LAW (NO EXCEPTIONS). A NON-REFUNDABLE DEPOSIT OF 50% IS REQUIRED WHEN ORDER IS PLACED, BALANCE DUE PRIOR TO SHIPMENT (UNLESS PRE-APPROVED TERMS ARE IN PLACE). CREDIT CARD OR CHECK PAYMENTS GLADLY ACCEPTED. ORDERS RECEIVED WITH INSUFFICIENT LICENSE OR PAYMENT INFORMATION WILL NOT BE PROCESSED UNTIL COMPLETE.