

FAMILY PRACTICE

DR. NAME, M.D.

123 PHYSICIAN WAY

ANYWHERE, U.S.A. 12345

(123) 456-7890 FAX: (123) 789-1234

DEA # PK111111 • LIC. # X12345

000001

11365020001

SECURITY FEATURES LISTED ON BACK

PATIENT NAME

DOB

GENDER

ADDRESS

PH. NO.

Quantity

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

Unit _____

Refills: 0 - 1 - 2 - 3 - 4 - 5

Do Not Substitute

Initials _____

Dispense As:

First Time Fill Refill

Signature _____

Date _____

RUB RED IMAGE



BLUE BACKGROUND. REFLECTIVE WATERMARK ON BACK.

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SECURITY FEATURES LISTED ON BACK

PATIENT NAME	DOB	GENDER	
ADDRESS	PH. NO.		
1)	Quantity: <input type="checkbox"/> 1-24 <input type="checkbox"/> 25-49 <input type="checkbox"/> 50-74 <input type="checkbox"/> 75-100 <input type="checkbox"/> 101-150 <input type="checkbox"/> 151-over Unit _____ Refills: 0 - 1 - 2 - 3 - 4 - 5 <input type="checkbox"/> Do Not Substitute Initials _____ Dispense As: <input type="checkbox"/> First Time Fill <input type="checkbox"/> Refill		
2)	Quantity: <input type="checkbox"/> 1-24 <input type="checkbox"/> 25-49 <input type="checkbox"/> 50-74 <input type="checkbox"/> 75-100 <input type="checkbox"/> 101-150 <input type="checkbox"/> 151-over Unit _____ Refills: 0 - 1 - 2 - 3 - 4 - 5 <input type="checkbox"/> Do Not Substitute Initials _____ Dispense As: <input type="checkbox"/> First Time Fill <input type="checkbox"/> Refill		
3)	Quantity: <input type="checkbox"/> 1-24 <input type="checkbox"/> 25-49 <input type="checkbox"/> 50-74 <input type="checkbox"/> 75-100 <input type="checkbox"/> 101-150 <input type="checkbox"/> 151-over Unit _____ Refills: 0 - 1 - 2 - 3 - 4 - 5 <input type="checkbox"/> Do Not Substitute Initials _____ Dispense As: <input type="checkbox"/> First Time Fill <input type="checkbox"/> Refill		

Signature _____ Date _____

RUB RED IMAGE



FADES WITH HEAT