PHYSICIAN
ADDRESS CITY STATE ZIPCODE
PHONE

DATE

SECURITY FEATURES LISTED ON BACK.

PATIENT NAME ______________________________ DATE ____________

ADDRESS ____

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VOID
AFTER__________________

DO NOT REFILL [ ]
REFILLS 1 2 3 4 5

SIGNATURE____

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON BACK. HOLD AT AN ANGLE TO VIEW.