



Prescription Authorization Form

Dear Customer,

Thank you for your interest in our products.

In order to process your order, Persys Medical is required to verify the license of the Medical Director or the physician in charge for the address of whom we ship prescription items as listed below:

Part Number	Description

I, Dr _____, Medical License number _____, State of _____, am the Medical Director or physician in charge for the location below. I request, under my license number, that PerSys Medical provide the above prescription items to the address listed below.

The prescription items will be used under my direction and supervision.

Account name	Shipping Address (please include state and zip code)	Contact phone	e-mail address

Physician Signature _____

Printed Name _____

Please send this form, along with a copy of your Medical License, faxed to 713-723-6221 or e-mailed to orders@ps-med.com