surgicalsupplyservice

EQUIPMENT & SUPPLIES FOR THE PODIATRIC PROFESSIONAL

MEDICAL DEVICE AUTHORIZATION FORM

If purchasing Medical Device, please complete sections A & B
If purchasing an Automated External Defibrillator (AED) unit, please complete sections A & C

Dear Valued Customer,

In order to ship you medical devices, we must have authorization from a licensed physician or other authorized prescriber. This individual needs to fill out the form below and fax a copy of this page and a photocopy of their license to 800-222-1934.

If your School/Facility does not have a licensed physician or other authorized prescriber, but is licensed to purchase prescription medical devices, please fax a copy of the license and this form for identification to 800-222-1934.

A) Name of School/Facility: ____________________

Attention: ____________________ Customer #: ____________________

Address: ____________________

City & State: ____________________ Zip: ____________________

Phone: ____________________ Fax: ____________________

E-Mail: ____________________

B) I hereby authorize the internally designated representatives named below to order prescription products for this School/Facility. (please print)

1. ____________________ 2. ____________________

Type of authorization: ❑ Unlimited ❑ Limited (please attach list of products)

Physician/Authorized Prescriber Signature: ____________________

Physician/Authorized Prescriber Name (please print): ____________________

* State License Number: ____________________

* DEA Registration Number: ____________________

* Must include photocopy of license

C) I hereby acknowledge that I am aware that medical devices are intended for use by a physician or a person certified or trained to use such device.

Name (please print): ____________________

Title: ____________________

State License/Certification Number: ____________________

Signature: ____________________ Date: ____________________