HologramRx manufactured by **ScriptShield**

535 2nd Street, S.W. • Vero Beach, FL 32962 • Tel 1-866-356-1050 TOLL FREE

Fax: 800-500-3060

FLORIDA PRESCRIPTION PAD ORDER FORM

THESE SCRIPTS CONTAIN AN EXCLUSIVE SECURITY HOLOGRAM THAT CANNOT BE COPIED, SCANNED, ERASED, LIFTED OR ALTERED.

*** *(SAMPLE FORMAT)* ***

1. DEA Number 2. NPI Number 3. LICENSE Number
4. NAME AND DEGREE OR CLINIC NAME
5. NAME, SPECIALTY, CLINIC OR HOSPITAL
6. STREET ADDRESS 7. SUITE
9. TELEPHONE 8. CITY, STATE, ZIP 10. FAX Number

PLEASE PRINT CLEARLY **AS YOU WOULD LIKE IT TO APPEAR ON THE SCRIPT**

1 DEA# ______________________ (only if you want preprinted on scripts)

2 LIC # ______________________ 3 NPI# ______________________
(only if you want preprinted on scripts) (only if you want preprinted on scripts)

4 Name 1 ______________________

5 Name 2 ______________________

6 Address ______________________ 7 Suite ______________

8 City ______________________ State ________ Zip ____________

9 Tel (_____)______________________ 10 Fax (_____)______________________
(only if you want preprinted on scripts)

Contact ______________________ ***Phone*** ______________________

E-MAIL ADDRESS: ______________________

Please CIRCLE the amount you want to order.

	SINGLE SHEET SCRIPTS Single scripts = 100 sheets per pad							***2-PART SCRIPTS** *2-PART = 50 Original scripts and 50 blank copy sheets						
Qty	800	1600	2400	3200	4000	4800	9,600	800	1600	2400	3200	4000	4800	9,600
	129.95	169.95	214.95	259.95	299.95	349.95	595.95	219.95	299.95	399.95	489.95	529.95	599.95	995.00
7% tax**	9.10	11.90	15.05	18.20	21.00	24.50	41.72	15.40	21.00	28.00	34.30	37.10	42.00	69.65
S/H	14.95	15.95	16.95	17.95	18.95	19.95	26.95	15.95	16.95	17.95	18.95	19.95	20.95	27.95
Total	**154.00**	**197.80**	**246.95**	**296.10**	**339.90**	**394.40**	**664.62**	**251.30**	**337.90**	**445.90**	**543.20**	**587.00**	**662.90**	**1092.60**

**If you are tax exempt, delete tax amount from total and supply copy of Tax exempt number

SCRIPTS WILL CONFORM TO YOUR LEGAL STATE FORMAT

DISC ☐ AMEX ☐
VISA ☐ M/C ☐ Number______________________ Expiry Date________

Address verification system for credit. **If you are paying by credit card, you MUST put the address where the credit card statement is sent when you receive your bill.**

Required: **PRINT** Cardholder's name ______________________

Address ______________________ Zip ____________

Cardholder's Signature ______________________ Title ____________ Date __________

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