EMBRACE HEALTHCARE
PHARMACY AND MEDICAL SUPPLY

Account Form

Name _____

Business Address _____

City _____ **County** _____ **State** _____ **Zip** _____

Telephone # w/area code: (_____) _____**Fax # w/area code: (_____)** _____

Email Address: _____

SHIPPING:

All supply and medication orders should be delivered to the following address:

Facility Name_____

Shipping Address _____

City _____ **County** _____ **State** _____ **Zip** _____

Credit Card Information (If applicable):

Name on Card: _____

Credit Card Number: _____ **Exp Date:** _____

ORDERING:

The following persons are authorized to purchase **Supplies and Prescription Drugs** for this account:

1. Name _____ Title _____Signature_____
2. Name _____ Title _____Signature_____
3. Name _____ Title _____Signature_____

RECEIVING:

The following persons are authorized to receive/pickup **Suplies and Prescription Drugs** for this account

1. Name _____ Title _____Signature_____
2. Name _____ Title _____Signature_____
3. Name _____ Title _____Signature_____

***Please note: Persons receiving/picking up orders will be required to show a valid drivers license**

PRODUCT CATEGORY AND LICENSE INFORMATION:

I, the undersigned, am the Medical Director or Pharmacist-in-Charge for the above-named facility at the above-specified shipping address. In this capacity I hereby authorize the facility to authorize the below-indicated category (ies) of products and submit the following referenced license(s) with respect to such orders, with a copy of such license (s)

_____I wish to order prescription drugs and/or Medical Devices. License authorizing these items is as follows:

Physician's License or State Board of Pharmacy License #_____Expiration Date:_____

Statement of Authority and Signature

I hereby swear under penalty of perjury that (I) I am the _____Medical Director or _____Pharmacist-in-Charge with responsibility for the facility identified above with respect to the specified address; (II) that the license information provided is current and accurate and I am, therefore, licensed to authorize shipment of the substances indicated on this form to the facility designated; and (III) I understand that failure to provide complete and truthful information may constitute grounds for the vendor to recommend that appropriate authorities bring disciplinary actions against me.

_____

Signature Date

_____

Print Name Print Title

Instructions:
This Authorization is only valid if accompanied by a copy of the license specified above. This Authorization will expire at the time of the expiration of the above-specified license (as applicable to the product ordered). Upon expiration, a new Authorization must be submitted for orders to be processed. If there is a change in Medical Director or Pharmacist-in-Charge, this Authorization will immediately become invalid and a new Authorization, including applicable license(s), must be submitted for orders to be processed.

Please mail, fax or email the completed form to:

Embrace Healthcare
3675 Dolson Court Carroll, OH 43112
Customerservice@embraceohio.org

Phone: (866) 406-3627
(740) 654-0800
Fax: (866) 413-3627
(740) 654-3433