



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 **Supplies 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
marketing@embraceohio.org

Phone: (866) 861-9656
(740) 329-1092
Fax: (877) 553-7372