

# PRESCRIPTION PAD ORDER FORM

PLEASE PRINT CLEARLY

DISTRIBUTOR NAME: \_\_\_\_\_ ACCOUNT #: \_\_\_\_\_  
EMAIL: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ PO#: \_\_\_\_\_

## PRESCRIBER INFORMATION

*\*REQUIRED FIELDS (PLEASE LIST ADDITIONAL PRESCRIBERS ON PAGE 2)*

PRACTICE NAME/LOCATION: \_\_\_\_\_

\* PRESCRIBER NAME: \_\_\_\_\_

SPECIALTY: \_\_\_\_\_

\* ADDRESS: \_\_\_\_\_

\* CITY/STATE/ZIP: \_\_\_\_\_

\* OFFICE PHONE: \_\_\_\_\_ OFFICE FAX: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

\* LICENSE #: \_\_\_\_\_ DEA# (INCLUDE IF STATE REQUIRED): \_\_\_\_\_

\_\_\_\_\_ PLEASE SPECIFY STATE NEEDED

NUMBER OF PADS	DESIGN	BACKGROUND	PROOF
<input type="checkbox"/> 4 PADS <input type="checkbox"/> 8 PADS <input type="checkbox"/> 12 PADS <input type="checkbox"/> 16 PADS	<input type="checkbox"/> VERTICAL (4.25 X 5.5)	<input type="checkbox"/> BLUE	<input type="checkbox"/> YES
<input type="checkbox"/> 20 PADS <input type="checkbox"/> 40 PADS <input type="checkbox"/> 60 PADS <input type="checkbox"/> 80 PADS	<input type="checkbox"/> HORIZONTAL (5.5 X 4.25)	<input type="checkbox"/> GREEN	<input type="checkbox"/> NO



Toll Free 888-815-9473 • www.wbf.com

**FAX: 770-442-9849**

wiserx pads@wbf.com

### SHIPPING

*Due to the sensitive nature of our products, we ship only to the prescriber address printed on your pads. All shipments require a signature upon delivery. Please call 888-815-9473 if you have any questions.*

**ADDITIONAL PRESCRIBERS/LOCATIONS**  
TOTAL # OF PRESCRIBERS: \_\_\_\_\_  
TOTAL # OF LOCATIONS: \_\_\_\_\_

**PAPER FEATURES**  
• 25# DocuChek Basic with TonerFuse  
• One Part  
• 100 Forms per pad

**SECURITY FEATURES**

- Chemical Reactive Paper
- Toner Adhesion Coating
- Invisible Fluorescent Fibers
- Void Pantograph
- Micro-printing
- Artificial Watermark
- Heat Sensitive Rx Symbol
- Security Features Listing on Back
- Erasable Ink
- Reverse Rx Symbol

## ADDITIONAL PRESCRIBERS

PRACTICE NAME/LOCATION: \_\_\_\_\_

\* PRESCRIBER NAME: \_\_\_\_\_

SPECIALTY: \_\_\_\_\_

\* ADDRESS: \_\_\_\_\_

\* CITY/STATE/ZIP: \_\_\_\_\_

\* OFFICE PHONE: \_\_\_\_\_ OFFICE FAX: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

\* LICENSE #: \_\_\_\_\_ DEA# (INCLUDE IF STATE REQUIRED): \_\_\_\_\_

PRACTICE NAME/LOCATION: \_\_\_\_\_

\* PRESCRIBER NAME: \_\_\_\_\_

SPECIALTY: \_\_\_\_\_

\* ADDRESS: \_\_\_\_\_

\* CITY/STATE/ZIP: \_\_\_\_\_

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PRACTICE NAME/LOCATION: \_\_\_\_\_

\* PRESCRIBER NAME: \_\_\_\_\_

SPECIALTY: \_\_\_\_\_

\* ADDRESS: \_\_\_\_\_

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