HealthSource
The SmarteRx Source

Before your order can ship the form below must be filled out and signed by the Licensee.

Name: _____

License #: _____

Account is for: ☐ Myself ☐ Medical Director for: _____

License State:_____License Type:_____

Practice Name: _____

Practice Address: _____Suite #: _____

_____

Please make sure all suite/unit numbers are included to avoid any potential shipping issues

By signing my name, I _____, affirm that I have knowledge of, approve, and am responsible for all prescription products ordered and delivered to the above location.
I affirm that such products are for use (administration or dispensing) in a valid Patient- Physician/Dentist/PA/NP relationship at the above listed professional practice, at the above listed address.

Signature (Cursive signature required): _____

Date: _____