



Authorization For Medical Directors and Pharmacists-in-Charge

A CUSTOMER AND SHIPPING INFORMATION

Please Print or Type:

Facility Name: _____ Account # _____

Contact Name: _____ E-mail address: _____

Company Shipping Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Does customer have multiple shipping addresses? Yes* No **If there is more than one shipping address, please include an attachment with additional addresses.*

B 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) attached to this form. [Please check appropriate box(es) and complete corresponding license information.]

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 # MA 60713 Expiration Date: 02/22/2018

I wish to order Controlled Substances: License(s) authorizing these items is as follows:

DEA License # _____ Expiration Date: _____

DEA license must be specific to shipping address. Please provide either medical director, pharmacists-in-charge or entity DEA license that corresponds to desired shipping location. Regardless of shipping address specified in Part A, controlled substances will ship to address corresponding to DEA license provided.

State Controlled Substance License # MM 0531132A Expiration Date: 06/03/2018

State controlled substance license is required for certain states. For those states, both the DEA and state license must be provided.

C STATEMENT OF AUTHORITY AND SIGNATURE

I hereby swear under penalty of perjury that (i) I am the (check one): Medical Director Pharmacist-in-Charge with responsibility for the facility identified above in Part A 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: Daniel Muse Date: _____

Print Name: Daniel Muse, MD Print Title: Physician

Instructions:

This Authorization is only valid if accompanied by a copy of the license specified in Part B. 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 complete this form and submit a copy of the appropriate license(s) to Customer Licensing by facsimile to 866-470-1355, by email to custlicense@sarnova.com, or by mail to P.O. Box 8023, Dublin, OH 43016-2023.