# 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 #**_______________ **Expiration Date:** ____________

☐ 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 #**_______________________ **Expiration Date:** ____________

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:** ___________________________ **Date:** __________

**Print Name:** __________________________ **Print Title:** ______________________

**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.***