California Security Prescriptions Order Form
(Controlled Substance RX)

10666 Los Alamitos Blvd. Los Alamitos CA 90720 | O 562.493.4547 F 562.594.6221 | nesi@printmasterlosal.com | www.printmasterlosal.com

By law, order must be delivered or shipped via certified mail to the address on state medical license or DEA registration.

Practice Name ______________________________

Address ______________________________ Suite __________

City ____________________ State _____ Zip Code __________

Email ______________________________

Phone ____________________ Fax ____________________

Practice Specialty (as you want it to appear on the prescription) ____________________

1. Physician ____________________ DEA# ____________________ CA LIC# __________

2. Physician ____________________ DEA# ____________________ CA LIC# __________

3. Physician ____________________ DEA# ____________________ CA LIC# __________

4. Physician ____________________ DEA# ____________________ CA LIC# __________

(Use a seperate sheet of paper if more room is needed)

Number of Pads 50 Sets per Pad		Size	Type		
❑ 4	❑ 8	❑ 5.5 x 4.25	❑ Single Page	❑ 1 Med per Script	❑ Wrap-around
❑ 12	❑ 16	❑ 8.5 x 3.66	❑ Carbonless Duplicate	❑ 2 Meds per Script	
❑ 20	other			❑ 3 Meds per Script	

Special Instructions (a pdf proof will be emailed)

***Ordered by*: Physician or Authorized Person:**

Print Name ____________________ Signature ____________________ Date __________

Phone/Fax/Email (if different than above) ______________________________

____

Please indicate the form of payment you intend to use: Visa Discover Mastercard Check

ALL ORDERS MUST BE ACCOMPANIED BY A COPY OF EACH PHYSICIAN'S DEA REGISTRATION AND STATE LICENSE (REQUIRED BY DOJ ON ALL ORDERS)

Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Name on Card: ____

Billing Address: ____

____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover

Credit Card Number: ____

Expiration Date: ____________ Card Identification Number: _______

Amount to Charge: $ _______________ (USD) Zip Code _______________

I authorize Printmasters to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: ____

Date: ____

Print Name: ____

Return the completed and signed form to the following:

Email: Nesi@printmasterlosal.com

Fax: 562-594-6221