

Rx PAD ORDER FORM: Medicaid-Compliant. Tamper-Resistant.

Order Type: New Repeat w/Change Exact Repeat

* Required Fields

*Contact Name _____ *Email _____
 *Address _____ *Phone # _____
 _____ *Fax # _____

Prescriber Information (as it will appear on the form) **(Enter Additional Prescribers on Page 2)**

*Clinic or Practice Name _____
 *Prescriber _____
 Specialty _____
 *Address _____ Ste _____
 *City _____ *State _____ *Zip _____
 *Phone#/Fax# _____
 *License _____ DEA# _____

Ship To: Check here if same as above.

Practice Name _____
 *Address _____ Ste _____
 *City _____ *State _____ *Zip _____

1-part Pads (100 sheets/pad) <i>(Must be ordered in increments of 8)</i>		2-part Pads (50 sets/book) <i>(Must be ordered in increments of 9)</i>	
<input type="checkbox"/> 4 pads	<input type="checkbox"/> 40 pads	<input type="checkbox"/> 9 books	<input type="checkbox"/> 81 books
<input type="checkbox"/> 8 pads	<input type="checkbox"/> 48 pads	<input type="checkbox"/> 18 books	<input type="checkbox"/> 117 books
<input type="checkbox"/> 16 pads	<input type="checkbox"/> 56 pads	<input type="checkbox"/> 27 books	<input type="checkbox"/> 162 books
<input type="checkbox"/> 24 pads	<input type="checkbox"/> 80 pads	<input type="checkbox"/> 36 books	<input type="checkbox"/> 252 books
<input type="checkbox"/> 32 pads	<input type="checkbox"/> 160 pads	<input type="checkbox"/> 45 books	

*Proof? Yes No
 *Background Blue Green
 *Layout Vert. Horiz.
 Logo? Yes No

(If you have a logo to print and we don't have it on file, please email us a high resolution JPG or EPS file.)

(For pricing, see [Rx Pad Pricing](#))

Sequential Numbering? Yes No Include GA Seal & Batch #? Yes No

(There is a single additional charge if either, or both, of these options are chosen.
 The GA Seal & Batch # are no longer required by the GA Board of Pharmacy.)

Additional Information: _____



MAIL ORDER FORM
 Shandy Creative Solutions
 2470 Windy Hill Road • Suite 164
 Marietta, GA 30067

Questions? Call or email:
 770.951.0305
 TOLL FREE 877.792.2177
 shandyg@mindspring.com

FAX ORDER FORM
 770.859.0120
 TOLL FREE 877.820.9157

ADDITIONAL PRESCRIBERS

Prescriber Information (as it will appear on the form)

* Required Field

* Clinic or Practice Name _____
* Prescriber _____
Specialty _____
* Address _____ Ste _____
* City _____ *State _____ *Zip _____
* Phone#/Fax# _____
* License _____ DEA# _____

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