

NJ LAW
NOW
REQUIRES
SEQUENTIAL
NUMBERING

National Rx Security, Inc.
535 2nd Street, S.W. • Vero Beach, FL 32962 • Tel 1-800-510-1050
Fax: 800-500-3060

N.J. PRESCRIPTION PAD ORDER FORM
For MD, DO, DDS, DMD, DPM, DVM, VMD, BVSc

*** (SAMPLE FORMAT) ***

- 1. NAME OF PROFESSIONAL PRACTICE
- 2. NAME & ACADEMIC DEGREE
- 3. IDENTIFICATION OF PROFESSIONAL PRACTICE OR SPECIALTY
- 4. ADDRESS

- * 6. DEA# (Prints only if requested)
- 9. BATCH # (Provided by printer)

- 5. CITY, STATE, ZIP
- 7. TELEPHONE / FAX
- 10. NPI # (10 Digits)

- 8. LICENSE # (12 Digits)
- 11. SERIAL # (Preprinted on script)

PLEASE NOTE THAT WE MUST SHIP PADS TO WHERE YOUR NJ LICENSE# IS REGISTERED WITH THE STATE. (TO VERIFY CALL 1-800-510-1050)

PLEASE PRINT CLEARLY AS YOU WOULD LIKE IT TO APPEAR ON THE SCRIPT

1 Name of Professional Practice _____

2 Name & Academic Degree _____

3 Identification of Professional Practice or Specialty _____

4 Address _____

5 City _____ State _____ Zip _____

6 *DEA# _____ 7 Tel. # (_____) _____ Fax: (_____) _____
**(Prints only if requested)*

8 Lic. # _____ 9 Batch # *(Provided by printer)*

10 NPI # _____ 11 Serial # *(Preprinted on script)*

Contact Name _____ **Phone#** _____

E-MAIL ADDRESS: _____

Please CIRCLE the amount you want to order.

SINGLE SHEET SCRIPTS

Single scripts = 100 sheets per pad

***2-PART SCRIPTS**

*2-PART = 50 Original scripts and 50 blank copy sheets

Qty	800	1600	2400	3200	4000	4800	9,600	800	1600	2400	3200	4000	4800	9,600
	59.95	84.95	114.95	144.95	179.95	199.95	359.95	94.95	109.95	154.95	220.95	284.95	334.95	614.95
S/H	12.95	13.95	14.95	15.95	16.95	17.95	19.95	13.95	15.95	16.95	17.95	18.95	19.95	21.95
Total	72.90	98.90	129.90	160.90	196.90	217.90	379.90	108.90	125.90	171.90	238.90	303.90	354.90	636.90

SCRIPTS WILL CONFORM TO YOUR LEGAL STATE FORMAT

DISC AMEX

Security Code _____

VISA M/C Number _____

Expiry Date _____

Address verification system for credit. If you are paying by credit card, you MUST put the address where the credit card statement is sent when you receive your bill.

Required: **PRINT** Cardholder's name _____

Address _____ Zip _____

Cardholder's Signature _____ Title _____ Date _____

SHIPPED WITHIN 4-5 DAYS FROM RECEIPT OF ORDER & PAYMENT