

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 Nurse Practitioner / Clinical Nurse Specialist

NJ LAW NOW
REQUIRES
SEQUENTIAL
NUMBERING

*****(SAMPLE FORMAT)*****
ONLY

- | | |
|--------------------------------------|-----------------------------------|
| 1 NAME, DEGREE | 4 CERTIFICATION # (12 DIGITS) |
| 2 ADDRESS | 5 BATCH # (Provided by Printer) |
| 3 CITY, STATE, ZIP | 6 TELEPHONE # |
| 7 * DEA # (Prints only if requested) | 9 SERIAL # (Preprinted on script) |
| 8 NPI # (10 Digits) | |

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

COLLABORATING PHYSICIAN

(Preprinting of collaborating Physician information is optional)

Name: _____ Lic #: _____

Address: _____

(Enter Address & Phone # only if different from Nurse.)

_____ Phone #: _____

1 Name & Degree _____

2 Address _____

3 City _____ State _____ Zip _____

4 Certif # _____ 5 Batch # *(Provided by printer)* 6 Tel. # (_____) _____

7 *DEA # _____ 8 NPI # _____ 9 Serial # *(Preprinted on script)*
**(Prints only if requested)*

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

	<u>Qty</u>	<u>800</u>	<u>1600</u>	<u>2400</u>	<u>3200</u>	<u>4000</u>	<u>4800</u>	<u>9,600</u>	<u>800</u>	<u>1600</u>	<u>2400</u>	<u>3200</u>	<u>4000</u>	<u>4800</u>	<u>9,600</u>
		77.95	110.95	149.95	188.95	233.95	259.95	467.95	113.95	131.95	185.95	264.95	341.95	401.95	737.95
	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		90.90	124.90	164.90	204.90	250.90	277.90	487.90	127.90	147.90	202.90	282.90	360.90	421.90	759.90

SCRIPTS WILL CONFORM TO YOUR LEGAL STATE FORMAT

DISC AMEX

VISA M/C Number _____ Security Code _____

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