

State of New Jersey
PRESCRIPTION BLANK

DOCTOR
SPECIALTY
STREET
CITY STATE ZIP
PHONE

NPI # _____

CERTIFICATION # _____

DEA # _____

COLLABORATING PHYSICIAN

NAME _____

LICENSE # _____

(Enter Address and Phone Number only if different from above)

ADDRESS _____

PHONE # _____

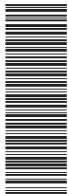
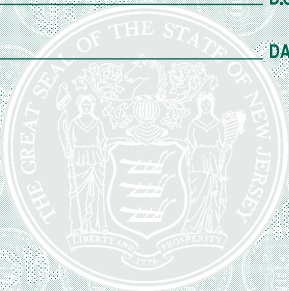
PATIENT _____

D.O.B. _____

ADDRESS _____

DATE _____

Rx



WL0000000000000

SUBSTITUTION PERMISSIBLE _____

DO NOT SUBSTITUTE _____

DO NOT REFILL _____

SIGNATURE OF PRESCRIBER

REFILL _____ **TIMES**

Use a separate form for each controlled substance prescription

THEFT, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY LAW