State of New Jersey

PRESCRIPTION BLANK

FACILITY NAME
DOCTOR
SPECIALTY
STREET
CITY STATE ZIP
PHONE

NPI # _____

LICENSE # _____

VALID ONLY FOR PRESCRIPTION EYEWEAR

PATIENT _____ D.O.B. _____

ADDRESS _____ DATE _____

Rx	SPHERE	CYLINDER	AXIS	PRISM
OD				
OS				
ADD		P.D. _____ / _____		
ADD		REMARKS:		

WL000000000000

DO NOT REFILL _____

REFILL _____ TIMES

SIGNATURE OF PRESCRIBER