

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:			



WL00000000000000

DO NOT REFILL _____

REFILL _____ **TIMES**

SIGNATURE OF PRESCRIBER

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