

State of New Jersey
PRESCRIPTION BLANK

NAME, DEGREE, TITLE
STREET • CITY STATE ZIP
PHONE

LICENSE # _____ DEA # _____

AFFILIATED PHYSICIAN

NAME **PHYSICIAN NAME** _____ LICENSE # **0000000** _____

TELEPHONE # **(000) 000-0000** _____

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