

TAMPER RESISTANT

PRESCRIPTION PADS & LASER FORMS

Benefits:

- Easy to order
- Fast Delivery
- Available in many different styles and sizes
- Secure shipment process
- Includes all Tamper Resistant required features
- Padded forms available in 1 or 2 part
- Laser Forms - Blank or Imprinted

Imprinted or Blank 8-1/2" x 11"

Additional features include: (optional)

- Printing on part 2 available
- Custom backprinting
- Numbering
- Padding in 50's (standard padding - 100's)
- Drilling on part 2

JOHN SMITH, M.D.
123 Your Address
YOURTOWN, USA 0000
(000) 000-0000

Rx

Name _____ DOB _____
Address _____ Date _____ M/F _____

Refill NR 1 2 3 4 5 Spanish

Void After _____

Do Not Substitute-Dispense As Written
Prescription is void if more than one (1) controlled substance is written per bar.

1-24
 25-49
 50-74
 75-100

Standard 5-1/2" x 4-1/4"
Landscape or Portrait

JOHN SMITH, M.D.
123 Your Address
YOURTOWN, USA 0000
(000) 000-0000

Rx

Name _____ DOB _____
Address _____ Date _____ M/F _____

Refill NR 1 2 3 4 5 Spanish

Void After _____

Do Not Substitute-Dispense As Written
Prescription is void if more than one (1) controlled substance is written per bar.

1-24
 25-49
 50-74
 75-100
 101-150

Security Prescription Security Prescription Security

THIS DOCUMENT CONTAINS THE FOLLOWING SECURITY FEATURES:

SECURITY FEATURES: SECURITY FEATURES:
VOID PRESCRIPTIONS: No valid VOID appears when document is photocopied.
SECURITY BACKPRINTING: When non-appropriate element appears on reverse side of document, word "VOID" is visible.
VOIDABLE ADJACENT FEATURES: Flare appear under each light source (fluorescent, incandescent, LED, infrared, & heat).
VOIDABLE VOID: No visible obstruction when illuminated by light source.

Security Prescription Security Prescription Security

Security Prescription Security Prescription Security

Rx

JOHN SMITH, M.D.
123 Your Address
YOURTOWN, USA 0000
(000) 000-0000

Name _____ DOB _____
Address _____ Date _____ M/F _____

Refill NR 1 2 3 4 5 Spanish

Void After _____

Do Not Substitute-Dispense As Written
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1-24
 25-49
 50-74
 75-100
 101-150

Semi-custom (Up to
8-1/2" x 5-1/2")
Portrait or Landscape

Rx

JOHN SMITH, M.D.
123 Your Address
YOURTOWN, USA 0000
(000) 000-0000

Name _____ DOB _____
Address _____ Date _____ M/F _____

Refill NR 1 2 3 4 5 Spanish

Void After _____

Do Not Substitute-Dispense As Written
Prescription is void if more than one (1) controlled substance is written per bar.

1-24
 25-49
 50-74
 75-100
 101-150

JOHN SMITH, M.D.
123 Your Address
YOURTOWN, USA 0000
(000) 000-0000

Rx

Name _____ DOB _____
Address _____ Date _____ M/F _____

Refill NR 1 2 3 4 5 Spanish

Void After _____

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1-24
 25-49
 50-74
 75-100
 101-150





Product Code	Parts	Forms/Pad	5 Pads	10 Pads	20 Pads	40 Pads	60 Pads	80 Pads	120 Pads	
Standard Pads										Price/Pad
<input type="checkbox"/> PC4-TR	1	100	16.00	9.40	6.40	4.90	4.50	4.20	4.10	
<input type="checkbox"/> PC4-TR2	2	100	22.10	13.00	9.50	7.90	7.60	7.30	7.20	
<input type="checkbox"/> PC4-TR3	3	50	N/A	17.60	11.90	10.20	9.50	9.20	9.00	
Semi Custom Pads										Price/Pad
<input type="checkbox"/> PCTR-SCUST	1	100	33.30	19.60	13.80	11.00	10.10	9.60	9.30	
<input type="checkbox"/> PCTR2-SCUST	2	100	50.00	29.40	20.90	17.20	16.20	15.80	15.40	
Laser - Imprinted				1000	2000	4000	6000	8000	10000	Price/M
<input type="checkbox"/> PRES1L-TR	1	Imprinted		193.00	143.00	124.00	116.00	114.00	112.00	
Laser - Stock				500	1000	2500	5000	10000	25000	Price/M
<input type="checkbox"/> PRES1L-TR-BK	1	Blank		60.00/lot	70.00	62.00	55.00	49.00	46.00	

Style: Landscape
 Portrait

Parts: 1 Part 2 Part 3 Part

Quantity: 10 Pads 20 Pads
 40 Pads 60 Pads
 80 Pads 120 Pads

Laser Quantity:

Imprinted 1000 2000 4000 6000 8000 10000
Blank 500 1000 2500 5000 10000 25000

Start Number: _____

Purchase Order # (if required) _____

Prices: (Add \$30 for Logo)
 Please send me your catalog

Additional features:

- 2nd part printing
- padded in 50's
- backprinting
- numbering
- drilling on part 2

****FAX ORDER FORM****

Practice Information

Practice: _____

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

License #: _____ DEA #: _____

NPI #: _____

Specialty: _____ Phone #: _____

Shipping address if different than above

Address: _____

Physician's Signature _____

(Required)