



SELECT QUANTITY	ITEM #	PER ORDER	UPGRADE SHIPPING SERVICE (per order)
<input type="checkbox"/> 1000 sheets (shipped in 1 carton of 2 reams)	EWCA1000	\$179.00*	<input type="checkbox"/> add \$30 UPS 2nd Day Air
<input type="checkbox"/> 2500 sheets (shipped in 1 carton of 5 reams)	EWCA2500	\$295.00*	<input type="checkbox"/> add \$50
<input type="checkbox"/> 5000 sheets (shipped in 2 cartons, 5 reams each)	EWCA5000	\$539.00*	<input type="checkbox"/> add \$100

\*Price per order includes UPS Ground Shipping Service. Upgraded shipping service is available for an additional charge.

Orders will ship within 9 days from receipt of order

**1 Designated Prescriber Information:**

\*Name: \_\_\_\_\_

\*Category of Licensure (ex: M.D.): \_\_\_\_\_

\*California State Medical License Number

\*DEA #

NPI #  (optional)

\_\_\_\_\_

Signature of Designated Prescriber

**2 Licensed Health Care Facility Information:**

\*Facility Name: \_\_\_\_\_

\*California Department of Health Services License Number: \_\_\_\_\_

*(Include a copy of the facility license with order form)*

Facility DEA # (if applicable)

\_\_\_\_\_

Signature of Designated Prescriber

\*Address Line 1: \_\_\_\_\_

Address Line 2: \_\_\_\_\_

\*City: \_\_\_\_\_

\*State: \_\_\_\_\_ \*ZIP Code: \_\_\_\_\_

\*Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Is this a 24-hour facility?  YES  NO — If no, please provide additional prescriber names to print on the forms in step 5

**3 Payment Information (select one):**

American Express  MasterCard  VISA

Check (Make check payable to Triple i) Check must be received before order can be processed

Card Number: \_\_\_\_\_





Card Expiration (MM/YYYY) \_\_\_\_\_

Card Holder Name: \_\_\_\_\_  
*(please print)*

Card Holder Signature \_\_\_\_\_

**4 Type of logo (please select one logo type):**

**Standard logo**

A   B   C   D 

**Customized logo**

Use my current logo on file

Use the new logo enclosed (*For new logos please provide a clean unfolded original on white paper*)

**No logo**

I do not wish to have a logo on my prescription pads.

**5 If your type of facility requires all prescribers' information to be preprinted on the forms, please print in spaces below (continued on next page if there are more than 4)**

1. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

2. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

3. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

4. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

Check here if continued on second page (please remember to include Facility name on 2nd page to ensure accurate delivery of forms)

ALL STATE MEDICAL LICENSE AND DEA #S WILL BE VERIFIED PRIOR TO PRINTING

**SIGN COMPLETED FORM, SIGN AND FAX TO: 1-800-233-9141 OR MAIL TO: PO BOX 1149, MORRISVILLE, PA 19067  
PLEASE CONTACT THE TRIPLE I CUSTOMER SERVICE CENTER IF YOU HAVE QUESTIONS: 1-800-969-7237**

# California Controlled Substance Prescription Forms

## Formatted for Exit-Writer Software

Please fill out Facility and Prescriber Information from previous page:

Facility Name: \_\_\_\_\_

Designated Prescriber: \_\_\_\_\_

**5**  Continued from previous page

5. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

6. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

7. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

8. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

9. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

10. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

11. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

12. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

13. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

14. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

15. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

16. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

17. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

18. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

19. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)

20. Prescriber Name \_\_\_\_\_

Category of License \_\_\_\_\_

State License #

DEA #

NPI #  (optional)