



**OurZen Inc.
Microcurrent Warehouse
Boca Raton, Florida, 33432**

Email: info@microcurrentwarehouse.com – Fax 866-860-8438

Physician's Prescription

Name of Patient: _____

Address: _____

Home Phone Number _____

Work/Cell Number _____

Reason for use of equipment

(Eg: Pain Reduction, Improved Functional Mobility, Stimulation of Soft Tissue Healing, Decreasing Ederna and Inflammation, Reduction of Muscle Spasms, etc.)

Prescription: Stimulation (select unit)

- a) Tens Unit
- b) Microcurrent
- c) Combo Unit TENS/EMS/MENS
- d) Interferential Unit
- e) Muscle Stimulator
- f) Conductive Garment

Name of Physician: _____

Address: _____

City/State/Zip _____

Physician Contact Number _____

Physician Fax Number: _____

I the undersigned certify that the above equipment is medical necessary for this patient. In my opinion the equipment will be purchased as a necessary in the standards of medical practice in the treatment of the above said patient. I confirm that the equipment is for the use of medical treatment and not prescribed as "Convenience" equipment

Physician's Signature

Date of Authorization
