

Prescription Form

THIS FORM REQUIRED FOR USA ORDERS ON ALL ELECTRO-MEDICAL DEVICES!
(Not required for international orders.)

(It is not necessary to use this form only)

Patient's Name _____

Address _____

City _____ State _____ Zip _____

Day Phone _____ Evening Phone _____

E-mail _____ Fax _____

Name of your licensed health care provider _____

License # _____

Dr's address _____

City _____ State _____ Zip _____

Diagnosis code _____

Doctor's Phone Number _____

Doctor's Signature _____