

# Order Form

## DEFENDER PLUS PRESCRIPTION PADS

PLEASE PRINT CLEARLY

Company Name _____	Date _____
Address _____	Phone No. _____
Fax No. _____	PO# _____

### Order Quantity

- **Single, Imprinted Pads** (100 sheets per pad)     RX#2 (5½"x 4¼" )     RX#1 (4 ¼" x 5½")    *Choose One*

Number of Pads: \_\_\_\_\_ (minimum 4 pads)

- **2-part, Imprinted Books** (50 sets per book, w/ ⅜" stub & wraparound cover)

RX#3 (5½"x 4¼" )     RX#4 (4¼" x 5½")    *Choose One*

Number of Books: \_\_\_\_\_ (minimum 8 books)

- **8½ x 11 Prescription Laser Sheets**     RX#5     RX#6     RX#7     RX#8     RX#9    *Choose One*  
(No imprint, shrinkwrapped in 250's)

Number of Sheets: \_\_\_\_\_ (minimum 500 sheets)

*\* Required Field*

### Prescriber Information

 (as it will appear on form; Order must ship to prescriber address)

Clinic or Business Name: \_\_\_\_\_

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

\* Address: \_\_\_\_\_    \* Suite: \_\_\_\_\_

\* City: \_\_\_\_\_    \* State \_\_\_\_\_    \* Zip: \_\_\_\_\_

\* Phone #: \_\_\_\_\_

\* License #: \_\_\_\_\_    DEA#: \_\_\_\_\_

*See Page 2 for additional Prescribers*

*(if State Required, include DEA #)*

Please see our Imprint sample sheet and choose preferred layout, or we can customize per your specifications.

"Style A"     "Style B"     Custom Layout (please clarify) \_\_\_\_\_

### Security Features

- Thermochromic Ink Verification Area
- Blue Void Pantograph
- Chemical Reactive Paper
- Invisible Florescent Fibers
- Safety Watermark Feature
- Microprinting
- Warning Border
- Security Backer Listing Features

### Other Features / Information

- Standard 3-5 day delivery on imprinted pads for most orders
- Blank sheet stock – 24 hour turnaround
- Valid in 42 states (excluding CA, FL, IN, KY, ME, NJ, WV, and WY)
- Samples are available upon request
- Provide artwork via Email, or we can set for you

# Additional Prescribers

PLEASE PRINT CLEARLY

\* Required Field

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\* Prescriber Name: \_\_\_\_\_  
\* Address: \_\_\_\_\_ \* Suite: \_\_\_\_\_  
\* City: \_\_\_\_\_ \* State \_\_\_\_\_ \* Zip: \_\_\_\_\_  
\* Phone #: \_\_\_\_\_  
\* License #: \_\_\_\_\_ DEA#: \_\_\_\_\_  
*(if State Required, include DEA #)*

\* Required Field

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*(if State Required, include DEA #)*