

Please complete all applicable fields. Please Print Clearly.

### Contact Information

First Name		Init	Last Name	
Address				
City	State	Zip	Country	
( )	( )			

### Refill Order Details

Medication	Strength	Quantity	RX	Price
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Shipping</b>				15.00 USD
<b>Total</b>				

### Shipping Information

Address		
City	State	Zip

### Payment Method

<input type="checkbox"/> VISA	<input type="checkbox"/> MasterCard
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### Credit Card Information

Card Holder Name	Credit Card Number	Expiry Date
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Where available, would you like to use generic drugs to save even more money?  Yes  No

I hereby waive my right to pharmacy counseling, as I have previously been counseled  Yes  No

Please do not contact me regarding this order, rather ship medication described above  Yes  No

I understand that all prices quoted and charges to my credit card will be in U.S. Dollars  Yes  No

Signature

Date

*Note: All pages of this document must be signed and dated in order to be processed.*