EMERGENCY MEDICAL PRODUCTS, INC.

License Authorization Form

A CUSTOMER AND SHIPPING INFORMATION

Facility Name:_____ **Account #**_____

Contact Name:_____ **E-mail address:**_____

Company Shipping Address: _____

City: _____ **State:** _____ **Zip:** _____ **Telephone:** _____

B PRODUCT CATEGORY AND LICENSE INFORMATION

As Medical Director or Pharmacist-In-Charge, I am licensed to authorize and do give my permission for the shipment of items from the designated product categories listed below (please check one). [Please check appropriate box(es) and complete corresponding license information.]

☐ Unlimited Medications and Medical Devices - No Narcotics (State license is required)

☐ Unlimited Narcotics, Medications, and Medical Devices (Federal DEA license is required)

☐ Limited Narcotics, Medications, or Medical Devices - Please list specific items:

_____

Physician's License or State Board of Pharmacy License #_____ **Expiration Date:** _____

☐ I wish to order Controlled Substances: License(s) authorizing these items is as follows:

DEA License #_____ **Expiration Date:** _____

DEA license must be specific to shipping address. Please provide either medical director, pharmacists-in-charge or entity DEA license that corresponds to desired shipping location. Regardless of shipping address specified in Part A, controlled substances will ship to address corresponding to DEA license provided.

State Controlled Substance License #_____ **Expiration Date:** _____

State controlled substance license is required for certain states. For those states, both the DEA and state license must be provided.

C STATEMENT OF AUTHORITY AND SIGNATURE

I hereby swear under penalty of perjury that (i) I am the (check one): ☐ **Medical Director** ☐ **Pharmacist-in-Charge with responsibility for the facility identified above in Part A with respect to the specified address; (ii) that the license information provided is current and accurate and I am, therefore, licensed to authorize shipment of the substances indicated on this form to the facility designated; and (iii) I understand that failure to provide complete and truthful information may constitute grounds for the vendor to recommend that appropriate authorities bring disciplinary actions against me.**

Signature: _____ **Date:** _____

Print Name: _____ **Print Title:** _____

Instructions:

This Authorization is only valid if accompanied by a copy of the license specified in Part B. This Authorization will expire at the time of the expiration of the above-specified license (as applicable to the product ordered). Upon expiration, a new Authorization must be submitted for orders to be processed. If there is a change in Medical Director or Pharmacist-in-Charge, this Authorization will immediately become invalid and a new Authorization, including applicable license(s), must be submitted for orders to be processed.

Please complete this form and submit a copy of the appropriate license(s) to Customer Licensing by facsimile to 800.558.1551 or by email to customerlicense@buyEMP.com.