



State of Florida Department of Health Approved "SECURE GUARD" Prescription Pad Order Form

Fax completed form to (813) 879-3516
or scan and e-mail to solutions@tampaprint.com

4410 W Hillsborough Ave • Tampa, FL 33614 • www.tampaprint.com
813-875-7083 • solutions@tampaprint.com

Since 1984

1. Contact Information - PLEASE PRINT - Date _____

Authorized Person
Placing Order: _____

Practice Name: _____

Phone: _____ Fax: _____

E-mail _____

A proof will be sent to you for your approval prior to printing.

>>>>>> Send Proof via: Fax E-mail

Do Not Write In This Area
For Tampa Print Only

Ack. _____

Date _____

TPS _____

V. Dr. _____

Adl. _____

Proof _____

Appvl. _____

2. Prescriber Information: (as you want it to appear on form) -Please Print Carefully.

* Required Information

(you may fax a current Rx form, please enlarge it before faxing)

Clinic or Practice Name: _____

* Prescriber Name _____

Specialty _____

* Address _____

* City, State, Zip _____

* Phone _____ Fax _____

* License# _____ DEA # _____

(If no DEA # is provided, we will leave a blank space for it to be written in)

Enter Additional Prescribers/Addresses On Page 2

Total Number of Prescribers _____ Total Number of Addresses _____

3. Quantity

Forms are 5.5" x 4.25"

Select

Orientation:

Horiz.

Vert.

"SECURE GUARD" One Part Forms

# Forms	# of Pads	Price
<input type="checkbox"/> 100	1	\$30.50
<input type="checkbox"/> 200	2	\$35.00
<input type="checkbox"/> 300	3	\$40.00
<input type="checkbox"/> 500	5	\$48.00
<input type="checkbox"/> 1000	10	\$68.00

"SECURE GUARD" Two Part Forms (top white, bottom yellow)

# Forms	# of Pads	Price
<input type="checkbox"/> 100	2	\$42.50
<input type="checkbox"/> 200	4	\$54.50
<input type="checkbox"/> 300	6	\$67.50
<input type="checkbox"/> 500	10	\$90.00
<input type="checkbox"/> 1000	20	\$146.00

No additional charge for set-up. Price does not include sales tax or delivery.

For additional quantities, sizes, or to order blank paper, please call for pricing.

4. Additional Prescriber Information:

* Prescriber #2 Name _____

Specialty _____

* License# _____ DEA # _____
(If no DEA # is provided, we will leave a blank space for it to be written in)

* Prescriber #3 Name _____

Specialty _____

* License# _____ DEA # _____
(If no DEA # is provided, we will leave a blank space for it to be written in)

5. Additional Address Information:

* Address #2 _____

* City, State, Zip _____

* Phone _____ Fax _____

* Address #3 _____

* City, State, Zip _____

* Phone _____ Fax _____

Additional Comments/Instructions:



Thank you for your order!

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