Pharma Pac
Point-of-Care Dispensing Solutions

SIGNATURE VERIFICATION - CONTROLLED SUBSTANCES CII - CIV

Doctors Name ______________________________

Facility Name ______________________________

DEA License# ______________________________

Signature ______________________________ Date ______________

AUTHORIZED PERSON(S)

Name ______________________________

License# ______________________________

Signature ______________________________ Date ______________

Name ______________________________

License# ______________________________

Signature ______________________________ Date ______________

Name ______________________________

License# ______________________________

Signature ______________________________ Date ______________

Name ______________________________

License# ______________________________

Signature ______________________________ Date ______________