

# Physician Only Products Authorization Form

Please complete this form and mail to: Mohawk Medical Mall PO Box 27, Utica, NY 13502 or Fax to 315.797.0365

Office Name: \_\_\_\_\_ Username: \_\_\_\_\_

Main Contact: \_\_\_\_\_

Address: \_\_\_\_\_

City & State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

In order to purchase "Physician Use Only" products, we must have a Physician's License on file. In addition this form must be completed with the signature of the license holder and returned to Mohawk Medical Mall with a copy of the DEA, State license, or both. We will only ship within the state of the Physician's license. We must also have an authorization signed by the Physician if someone besides the physician is purchasing the "Physician Use Only" products.

Individual(s) Authorized to Purchase: \_\_\_\_\_

Choose One:

DEA Registration Number  
\*Copy Required

State License Number  
\*Copy Required

# \_\_\_\_\_ Exp. Date \_\_\_\_\_

# \_\_\_\_\_ Exp. Date \_\_\_\_\_

I hereby authorize the above designated individual(s) to purchase Physician Only Products. I fully understand Mohawk Medical Mall's Physician Use Only Policy and certify that all the information on this form is correct.

Physician's Signature: \_\_\_\_\_

Physician's Name (Please Print) : \_\_\_\_\_

Date: \_\_\_\_\_

