



Mohawk Hospital Equipment (DBA Mohawk Medical Mall)
 247 Elizabeth St. Utica, NY 13501
 a New York State Corporation
 1.855.366.4295 www.MohawkMedicalMall.com

Prescription Drug / Device Authorization Form

Mohawk Hospital Equipment, operating the ecommerce website www.MohawkMedicalMall.com, requires a signed Prescription Drug/Device Authorization Form and a legible copy of the professional license referenced on the form in order to sell and ship prescription pharmaceuticals and prescription-designated medical devices in compliance with federal law. Acceptable credentials include a valid Federal DEA license (Controlled Substance Registration Certificate), pharmacy license, certificate of need, or other qualifying healthcare, dental or veterinary professional license with prescriptive authority. The form must be completed by the individual listed on the license, or by a healthcare professional, supervising pharmacist or administrator who holds or oversees a license that legally authorizes the procurement of prescription drugs or prescription-designated medical devices. The individual completing the form accepts full responsibility for all purchases and shipments to the designated location(s). Authorization must be renewed upon expiration of the submitted license and will only be granted for addresses located within the same state as the issued license.

Facility Name:	MohawkMedicalMall Order#:		
Address:	Suite or Room #:		
Address:	City:	State:	Zip:

To authorize additional locations, please provide a list of full addresses (including suite or room numbers, if applicable).
 The individual signing this form must sign the attached list to validate the submission.

License Type:

Federal DEA License (Controlled Substance Registration Certificate)

By signing this document, I authorize the use of my Federal DEA license for the location(s) specified above, solely for the purpose of purchasing prescription drugs and/or prescription medical devices. I further agree to notify Mohawk Medical Mall immediately if my responsibility status or relationship with the location(s) changes or terminates.

DEA Registration # *Please include copy of actual license (online verification not accepted)*

Signature of Licensee

Print Licensee Name:

Email Address: **Phone#**

Pharmacy License

Certificate of Need

Wholesale Pharmaceutical License

By signing this document, I acknowledge and agree that the pharmacy license, certificate of need or wholesale pharmaceutical license provided shall be used exclusively for the purchase of prescription drugs and/or prescription medical devices. I accept full responsibility for overseeing all such purchases. Furthermore, I agree to promptly notify Mohawk Medical Mall of any change or termination in my responsibilities or in my relationship with the designated location(s).

License or Certificate# *Please include copy of actual license or certificate (online verification not accepted)*

Signature of Overseer

Print Overseer Name:

Email Address: **Phone#**

Please email this completed form and copy of license or certificate to service@MohawkMedicalMall.com or fax to 315-797-0365