

ORDER FORM

GENERICDRUGSUPERSTORE

Please fax back toll-free 1-866-982-9542

(Please Print)

YOUR ORDER

DRUG NAME	Strength	Quantity	Price (USD)
*Attach an additional sheet if you require more space		Shipping	\$10.99
		TOTAL	

YOUR PRESCRIPTION(S):

Enclosed My Doctor is faxing them to you Please contact me

PERSONAL INFORMATION:

First Name Middle Initial Last Name Gender: Male Female

Date of Birth: _____ (MM/DD/YYYY) Weight: _____ lbs

PHYSICIAN INFORMATION:

Primary Physician Name: _____

Street: _____ Phone: () _____

City: _____ Fax: () _____

DRUG PACKAGING: Please supply me with child resistant containers/packaging
 No, do not supply me with child resistant containers/packaging

