

PUBLIC SAFETY STORES



PROTECTING THE PROTECTORS

Public Safety Stores
1600 Valley River Drive
Eugene, OR 97401
Toll Free: 866 646-4434 ♦ Fax: 541-686-1373
sales@publicsafetystores.com
www.publicsafetystores.com

Medical Authorization Form

Customer/Facility Name:		Customer ID: (If Available)	
Customer/Facility License Number:		License Expiration Date:	
Contact Name:		Contact Phone Number:	
Email Address:			
Address:	City:	State:	Zip:

The following section is to be completed by your Medical Director, Physician or Pharmacist.

As a Medical Director (Physician) or Pharmacist, I am licensed to authorize and do give my permission for the customer above to purchase *Unlimited* Medications and Medical Devices (No Narcotics).

Medical Director's (Physician's) or Pharmacist's License Number: _____ **Expiration Date:** _____
(A copy of your License must be submitted with this form)

Medical Director (Physician) or Pharmacist Name: (Please Print)	Title:
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submit a copy of the appropriate customer/facility license(s)
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