Wishard Health Services

The Department of Pharmacy Services at Wishard Health Services is required to maintain a record of prescriber signatures and DEA numbers for verifications of prescriptions. Please provide the following information and return this form to the Pharmacy Administration Office so that we may properly process the prescriptions you prescribe for your patients.

FOR PHARMACY AND MEDICL RECORDS USE ONLY

REGISTRY OF SIGNATURE

DATE ____________

NAME (PRINTED) ____

ADDRESS ____
____
____

SERVICE/DEPARTMENT ____

Check: ____Intern ____Resident ____Fellow ____Staff ____Other: ___________

STATE MEDICAL LICENSE NUMBER ____

SOCIAL SECURITY NUMBER ____

DEA NUMBER ____
(or hospital assigned #)

SIGNATURE ____

SAMPLE INITIAL __________________
(or approved credential initials)

TELEPHONE Office ______________
Home ______________
Pager ______________
Fax ______________

WHS COMPUTER # ______________

E-MAIL ADDRESS ______________________________

Additional information required for credentialed practitioners with prescriptive authority:

Specialty Area ______________________________ Other Certification #s ______________
____

Nursing Board Certification # RN ______________

NP ______________

Assigned State/Fed. ID # ___________

Name of Collaborating Health Practitioner: ____

Specialty Area of Collaborating Practitioner: ____