Provider Data Sheet
for Compounded Prescription Compliance

Provider Name: _____

Clinic Name: _____

Clinic Address: _____

Clinic City: _____ **State:** _____ **Zip:** _____

Clinic Phone: ( ) _____ **Provider Cell Phone: ( )** _____

Clinic Fax: ( ) _____ **Provider Email:** _____

Clinic Email: _____ **Website:** _____

Best Contact Person: _____

Type of Practice: _____ **# of Practitioners:** _____

Provider Medical License # and State: _____

Provider DEA# _____ **Provider NPI#** _____
(A copy of your DEA and Medical License is required to be sent with this data sheet.)

Please answer the following questions:

1. Preference for contact from the pharmacy? (circle one) Email Phone
2. Do you currently prescribe for Hormone Therapy? (circle one) Yes NO
3. Are you willing to receive referrals from the pharmacy? (circle one) Yes NO
4. How did you hear about Pharmacy Solutions? _____

Provider Agreement:

Controlled substances must be written and faxed to the pharmacy with a valid provider signature. Controlled substance prescriptions cannot be written for myself. Internet diagnosing without a face-to-face appointment is illegal in most states and I as a provider have to establish a Provider/Patient relationship before prescriptions are sent to Pharmacy Solutions. I understand that the law for prescribing HCG and anabolic steroids must have a recognized medical diagnosis as approved by the FDA. Further, I ***DO NOT*** prescribe hormones for sports enhancement or body building.

I acknowledge that the information presented on this form is accurate and complete.

Provider's Signature _____ **Date** _____

Please send this signed document back to
Pharmacy Solutions, 5204 Jackson Road, Suite C, Ann Arbor, Michigan 48103 or fax to 734.821.8001. Thank you.