Washington Teamsters Retiree's Welfare Trust
Mail Order Prescription Order Form

Patient Name	Patient ID #	Patient Date of Birth

Shipping Address ☐ new address	Email Address
City, State, Zip Code	Daytime Phone
List any Chronic Medical Conditions / List any Drug Allergies	Evening Phone
	Visa or Mastercard No. Exp. Date
	Transfer Pharmacy Name & Phone (if applicable)

Rx Number	Name of Drug	Strength	Generic ok?	Quantity	Days Supply	Prescribing Practitioner

I Certify the information given here is correct and authorize my pharmacy to fill the enclosed and/or listed prescriptions.

Child Resistant Cap? ☐ **Yes**
Please Initial ☐ **No**

Patient's Signature _____ Date