



Authorization for Purchase of Medical Devices

1	CUSTOMER AND SHIPPING INFORMATION
<p><i>Please Print or Type:</i></p> <p>Company Name: _____ Account # _____</p> <p>Contact Name: _____ E-mail _____</p> <p>Authorized Purchaser(s): _____, _____, _____</p> <p>Address: _____, City: _____, State: _____, Zip: _____</p> <p>Company Shipping Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Telephone: _____ Alternate Telephone: _____</p> <p><small>*If there is more than one shipping address, please include an attachment with additional addresses.</small></p>	
2	PRODUCT CATEGORY AND LICENSE INFORMATION
<p>I, the undersigned, am the Medical Director or Physician in charge for the above-named facility at the above-specified shipping address. In this capacity, I hereby authorize the purchase and shipment of the below-indicated category of product(s) and submit the following referenced license(s) or prescription(s) with respect to such orders, with a copy of such license(s) or prescription(s) attached to this form.</p> <p>___ Unlimited Legend Medical Devices (Examples: IV Catheters & IV sets, Needles & sharps, Syringes, ET Tubes, LMA's, Combitubes, etc). <i>By selecting this option all categories will be available for purchase.</i></p> <p>___ Limited Legend Medical Devices (Examples: Suction unit, Pulse Oximeter, bag valve mask (BVM), ventilator, hemostatic dressing, etc). <i>Please indicate which category is requested on page 2 of this form.</i></p> <p>Physician's License or State Board of Pharmacy License # _____ Expiration Date: _____</p>	
3	STATEMENT OF AUTHORITY AND SIGNATURE
<p>I hereby swear under penalty of perjury that (i) I am the (check one): ___ Medical Director ___ Physician in charge; with responsibility for the facility or individual identified above in Part A with respect to the specified address; (ii) that the license and or prescription information provided is current and accurate and I am, therefore, licensed to authorize shipment of the products indicated on this form to the facility designated; and (iii) I understand that failure to provide complete and truthful information may constitute grounds for the vendor to recommend that appropriate authorities bring disciplinary actions against me.</p> <p>Physician Signature: _____ Date: _____</p> <p>Print Name: _____ Print Title: _____</p> <p>Instructions: <i>This Authorization is only valid if accompanied by a copy of the license or prescription(s) specified in Part 2. This Authorization will expire at the time of the expiration of the above-specified license or prescription(s) (as applicable to the product ordered) or 2 years from submission; whichever comes first. Upon expiration, a new Authorization must be submitted accompanied by the appropriate license or prescription(s) for orders to be processed. If there is a change in Medical Director, Physician in charge, or Authorized purchaser, this Authorization will immediately become void and a new Authorization, including applicable license(s) and or prescription(s), must be submitted for orders to be processed.</i></p>	

Please complete this form and submit a copy of the appropriate license(s) or prescription(s) to Witmer Public Safety Group, Inc. by facsimile at 888-335-9800, by email to sales@theemsstore.com, or by mail to 104 Independence Way, Coatesville Pa. 19320 ATTENTION: Sales at theEMSstore.



4 Product Categories

1. ___ IV Catheters
2. ___ IV Admin Sets & Supplies
3. ___ Syringes
4. ___ Sharps & Needles
5. ___ Ventilator & Supplies
6. ___ CPAP & Supplies
7. ___ Rescue Airways
8. ___ ET Tubes & Supplies
9. ___ Video Laryngoscope
10. ___ Suction Units & Supplies
11. ___ Hemostatic agents
12. ___ Oxygen Supplies
13. ___ Pulse Oximetry
14. ___ Cardiac Supplies
15. ___ Trauma Supplies

Physician Signature: _____ **Date:** _____