



RX Products
You Know and Trust

983 12th Street • Vero Beach, FL 32960 • Toll Free 800-510-1050

Fax: 800-500-3060 • Local Fax: 772-567-4609

PRESCRIPTION PAD ORDER FORM

**THESE SCRIPTS CONTAIN AN EXCLUSIVE SECURITY HOLOGRAM THAT
CAN NOT BE COPIED, SCANNED, ERASED, LIFTED OR ALTERED.**

PLEASE PRINT CLEARLY AS YOU WOULD LIKE IT TO APPEAR ON THE SCRIPT

For multiple locations/providers, please attach a second sheet with enlarged script sample or written out instructions.

1 DEA# _____ (only if you want preprinted on scripts)
2 LIC# _____ 3 NPI# _____
(Only if you want preprinted on scripts) (Only if you want preprinted on scripts)
4 Name 1 _____
5 Name 2 _____
6 Address _____ 7 Suite _____
8 City _____ State _____ Zip _____
9 Tel (_____) _____ 10 Fax (_____) _____

☐ Shipping address different than Script address, please list on separate sheet.

(Only if you want preprinted on scripts)

*** Please CIRCLE IN INK the amount you want to order ***

SINGLE SHEET SCRIPT PADS (HOLOGRAM) Single Scripts = 100 sheets per pad								*2-PART SCRIPTS PADS (HOLOGRAM) *2-Part = 50 Original scripts and 50 blanks copy sheets							
Qty	8	16	24	32	40	48	96	8	16	24	32	40	48	96	
	\$173.00	\$221.00	\$284.00	\$340.00	\$397.00	\$460.00	\$821.00	\$260.00	\$351.00	\$463.00	\$569.00	\$627.00	\$707.00	\$1189.00	
Set-up	25.00	25.00	25.00	25.00	25.00	25.00	25.00	25.00	25.00	25.00	25.00	25.00	25.00	25.00	
S/H	19.75	21.75	23.75	26.75	28.75	30.75	55.75	21.75	24.75	28.75	35.75	38.75	44.75	68.75	
Total	\$217.75	\$267.75	\$332.75	\$391.75	\$450.75	\$515.75	\$901.75	\$306.75	\$400.75	\$516.75	\$629.75	\$690.75	\$776.75	\$1292.75	

Contact _____ Phone _____

Email Address: _____

Contact information is for us to reach you with regard to your order and will not be printed on the scripts.

SCRIPTS WILL CONFORM TO YOUR LEGAL STATE FORMAT

☐ DISC ☐ AMEX EXPIRY DATE _____
☐ VISA ☐ M/C NUMBER _____ SECURITY CODE _____

* Address verification system for credit. If you are paying by credit card, you MUST put the address where the credit card statement is sent when you receive your bill.

Address _____ Zip _____

Print Cardholder's Name _____

Cardholder's Signature _____ Title _____ Date _____

If mailing a CHECK for payment, please make check payable to: **Minuteman Press**

Visit us at RxMinutemanPress.com

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