



Pocket BVM Prescription Authorization Form

Dear Customer,
In order to process your order for the *Pocket BVM*, we are required to have on file approval by the *Medical Director* or the *Physician in Charge* for the address receiving the prescription items.

Item	Description
Pocket BVM	Disposable, silicon based resuscitator that expands from a disc-like protective case to a full size, functional respirator.

I, Dr. _____, Medical License No: _____,
State of _____, am the *Medical Director* or *Physician in Charge* for the location stated below.
I request, under my license number, that A.C.T.N.T. Healthcare Services provide the above prescription items to the address listed below.

The prescription items will be used under my direction and supervision.

Facility/Agency	
Contact Person	
Shipping Address	
City/State/Zip	
Contact Phone	
E-mail	

Physician Signature _____ Date _____

Print Name _____

Please send this form by fax: 940-325-0590 or by email: sales@actnt.com.