Custom Medical Solutions for the Harshest Environments on Earth

Medical License Authorization Form

In order to sell and ship prescription pharmaceuticals to you, we must receive written authorization from the responsible physician at your place of business or service. Please have the authorizing physician complete this form and return to us, along with a copy of the medical license.

We are a licensed drug wholesaler that distributes regular prescription drugs. We do not distribute controlled prescription drugs.

Medical License Holder Name: ____
Medical License Number:____
Licensing Authority: ____
Date of Expiration: _______________________

Billing Entity Name: ____
Billing Address: ____
City: __________________________ State: _______________ Zip: _______________
Phone:________________________ Email:____________________________________

Authorized Shipping Locations:

Shipping Location 1:____
Shipping Address:____
City:__________________________ State:__________________ Zip:_____________
Phone:________________________ Email:____________________________________

Shipping Location 2:____
Shipping Address:____
City:__________________________ State:__________________Zip:_____________
Phone:________________________ Email:____________________________________

If you have more than 2 shipping locations please attach additional page

Medical License Holder Signature:_____________________________
Date:__________________

Please email copy of Medical License and Completed Authorization to admin@chinookmed.com or fax to 970-375-6343

12505 E. 55th Street, Unit B • Tulsa, OK 74146 • USA
Phone: 970.375.1241 • Fax: 970.375.6343 • Email: admin@chinookmed.com
www.chinookmed.com