Board of Pharmacy

CONTROLLED SUBSTANCES MONITORING PROGRAM

Phone (304) 558-8411
Fax (304) 558-0474

Office
232 Capitol Street
Charleston, West Virginia 25301

PHARMACY REQUEST FORM FOR PSEUDOEPHEDRINE
PLEASE FILL OUT COMPLETELY. WILL BE FAXED BACK IF ANY FIELDS ARE LEFT BLANK

Subject's Name: _____
First Middle Last

Address: _____

_____ _____ _____ _____
City County State Zip Code

Date of Birth: _____ (cannot process without birth date)

Aliases (if known):

Report Period Requested: From _____ to _____
Date Date

_____
Pharmacy Name

_____
Printed name of Pharmacist

_____ _____
Street Address Store DEA #

_____
City, State, Zip

_____ _____
Telephone FAX

I certify that the information will be used for the purpose of providing medical or pharmaceutical treatment.

_____
Signature of Pharmacist