Board of Pharmacy Wellness Program
Sponsored by the Alabama State Board of Pharmacy
P.O. Box 381988
Birmingham, AL 35238-1988

VERIFICATION OF PRESCRIBED MEDICATION

NOTICE TO PRESCRIBING PRACTITIONERS. **RE:** _____
NAME OF PHARMACIST, INTERN OR TECHNICIAN

To the practitioner of the Alabama Board of Pharmacy Monitoring participant:

The individual who is providing this form is a participant in the Alabama Board of Pharmacy Monitoring Program. As part of the program, the pharmacist, intern or technician is to provide documentation of all prescribed medications.

Please take a few minutes to complete the form below. After completing the form, please mail it to the program office at the address listed above or fax to (251) 252-9112. **The practitioner must mail the form**. If you have any questions, please call the program staff at (205) 981-2273 or (251) 866-5585.

PRESCRIPTION INFORMATION

Date of Prescription	Type of Medication	Quantity and Dosage Prescribed/Number of Refills	Reason for Medication

I acknowledge that my patient has informed me that he/she has a _____ problem.

_____ _____
Name Practitioner Signature

_____
Address

_____ _____
Date

_____
Office Telephone Number

Rev: October 20, 2011