



**PERSONAL INFORMATION**

Full Name (please print clearly)  Male  Female

Street Address

City State/Province Country Zip/Postal Code  
( ) ( ) ( )

Phone (Home) Phone (Other) / /

Email Birthdate (MM/DD/YY)

Best time to be contacted

Please check if you are placing this order for a pet.  
 Cat  Dog  Other  
(Please specify)

**MEDICATIONS TO ORDER**

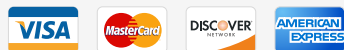
Please enter the quantity and listed price for the medication(s) you wish to order, as obtained through our website or customer service center. An original prescription from your doctor's office is required (faxed, mailed, emailed or called in from your Doctor). **PRICING IS IN \$US DOLLARS.**

GENERIC OK?	MEDICATION	STRENGTH	QTY	PRICE
<b>SUB TOTAL:</b>				
<b>SHIPPING (USA):</b>				<b>\$7.00</b>
<b>TOTAL:</b>				

**PAYMENT OPTIONS**

**Pay by Credit Card**

- Please call me to obtain my credit card information
- I will fax in the credit card information form to the designated credit card information fax line at 1-877-496-1623



Please note that in order to comply with the Payment Card Industry (PCI) Security Standard Council's requirements for the protection of your credit card information we are only able to accept your credit card information via the two methods mentioned above or through our secure online ordering system.

**Personal Checking Account (Check or EFT)**

USA Only

- Use my check information "on file"
- I will send a VOIDED check by:
  - Fax  Email  Mail
- I will make a payment by check, and mail it to

**Mailing Address:**

#501-2906  
West Broadway,  
Vancouver, BC,  
Canada V6K 2G8

**FIRST TIME PATIENTS**

(please fill out this section if you are a first time patient, or to update your information.)

**Your Physician**

Primary Physician's Name

Clinic Name, Street Address

City State/Province Country Zip/Postal Code  
( ) ( ) ( )

Phone Number Ext. Fax Number

**Allergies**

Do you have any known drug allergies?  Yes  No  
If yes, please enter the drug(s) you are allergic to:

**Medication, OTC, Herbal Products You Are Currently Taking**

(only list medications you are not ordering)

MEDICATION	DOSAGE	FREQUENCY

**PRESCRIPTION SUBMISSION**

(please select one of the three options below.)

**Option 1. Call My Doctor**

Physician's Name

Clinic Name, Street Address

City State/Province Country Zip/Postal Code  
( ) ( ) ( )

Phone Number Ext. Fax Number

**Option 2. Transfer from another pharmacy**

Pharmacy Name

Street Address

City State/Province Country Zip/Postal Code  
( ) ( ) ( )

Phone Number Ext. Fax Number

**Option 3. Mail or Fax Your Prescriptions**

**Fax To:** 1-866-783-4223 **Mail To:** #501-2906 West Broadway, Vancouver, BC, Canada V6K 2G8

**PATIENT AUTHORIZATION**

(please check one)

www.UniversalDrugStore.com operates as call centre and marketing company with offices in Canada and elsewhere. We specialize in connecting customers with pharmacies internationally as well as within Canada. The following terms and conditions shall govern all sales delivered by www.UniversalDrugStore.com (the "Provider"), and its authorized pharmacies and the individual (the "Customer") regarding products offered for sale. The Customer herein represents to the Provider that:

- I am of the age of majority, and:
  1. I have accurately disclosed all my personal health information and consent for the Provider to use it for the purposes of filling my prescription orders. Within the last 12 months, I have seen a physician and I do not require a physical examination at this time.
  2. I understand that all medicine shall be dispensed and sold by a pharmacy operating internationally and following the laws of that jurisdiction.
  3. I hereby authorize the Provider, as my attorney and agent, to do all that is required to obtain a valid prescription for any and all medicines as required, as well as packaging and delivering the medicine to an address that I provide. This authorization shall include, but not be limited to: collecting and using my personal health information for the purpose of fulfilling all prescription orders and disclosure to a licensed physician if necessary to issue a new valid prescription in the Pharmacy's jurisdiction. The provider shall act for me as though I was personally present at the pharmacy itself.
  4. I understand that each pharmacy is authorized to carry on the business of pharmacy and that I am purchasing medications that are licensed or approved for sale by the pharmacy. Title to my medications passes from the pharmacy to me in as soon as the products are released from the pharmacy. All agreements and contracts formed shall be deemed to take place in the jurisdiction of the pharmacy and the laws of the jurisdiction of the pharmacy shall apply. I attorn to the courts of the jurisdiction of the pharmacy, which shall have exclusive jurisdiction over any and all disputes that may arise between myself and the pharmacy, its officers and directors.

**I HAVE READ AND UNDERSTAND THESE TERMS AND AGREE THAT THEY SHALL BE BINDING UPON ME AND MY ASSIGNS, HEIRS AND PERSONAL REPRESENTATIVES."**

**OR**

- "I am the parent/legal guardian/power of attorney for the Patient disclosed herein, am over the age of majority, and have full authority to sign for and provide the above representations to the Pharmacy on the Patient's behalf."

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date (MM/DD/YY)



**PLEASE FAX THIS CREDIT CARD AUTHORIZATION FORM TO  
TOLL FREE FAX NUMBER: 1-877-496-1623**

**Credit Card Authorization Form**

Sign and complete this form to authorize Universal Drug Services to charge your credit card listed below.

PLEASE FAX THIS COMPLETED FORM TO 1-877-496-1623.

**IMPORTANT: DO NOT FAX THIS FORM TO THE SAME FAX NUMBER THAT YOU FAX YOUR ORDER FORM.**

By signing this form you give us permission to debit your credit card for orders that you place with our company.

**PLEASE COMPLETE THE INFORMATION BELOW:**

I \_\_\_\_\_ authorize Universal Drug Services to charge my credit card account,  
(full name) indicated below, for orders which I place.

**Billing Address:** \_\_\_\_\_ **Phone#** \_\_\_\_\_

**City, State, Zip** \_\_\_\_\_

**Account Type:**       Visa       MasterCard       AMEX       Discover

**Cardholder Name:** \_\_\_\_\_

**Credit Card #:** \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_

**CVV2** (3 digit number on back of Visa/MC, 4 digits on front of AMEX) \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above.  
I certify that I am an authorized user of this credit card and that I authorize your company to bill my credit card for my orders.