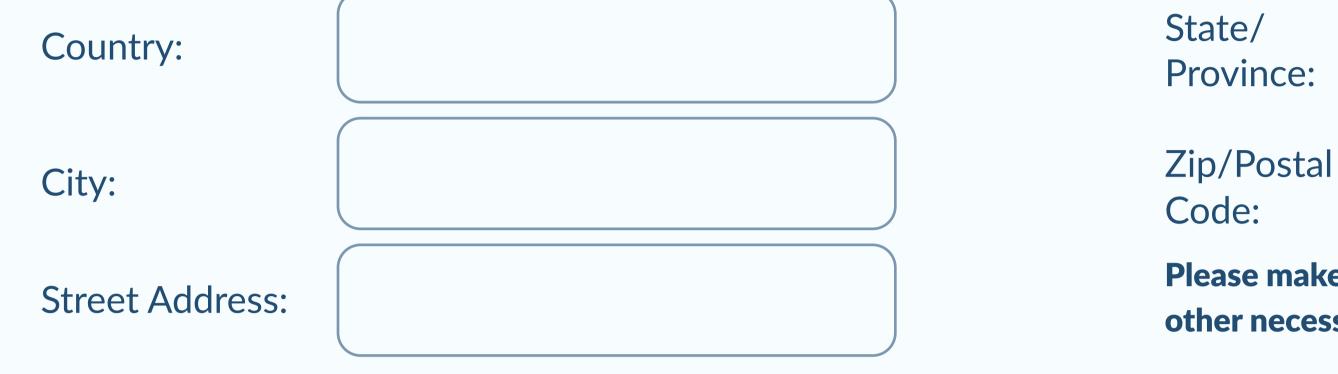


Medication Order Form

Please fill out the following form to place your medication order. Ensure all information is accurate to avoid delays in processing.

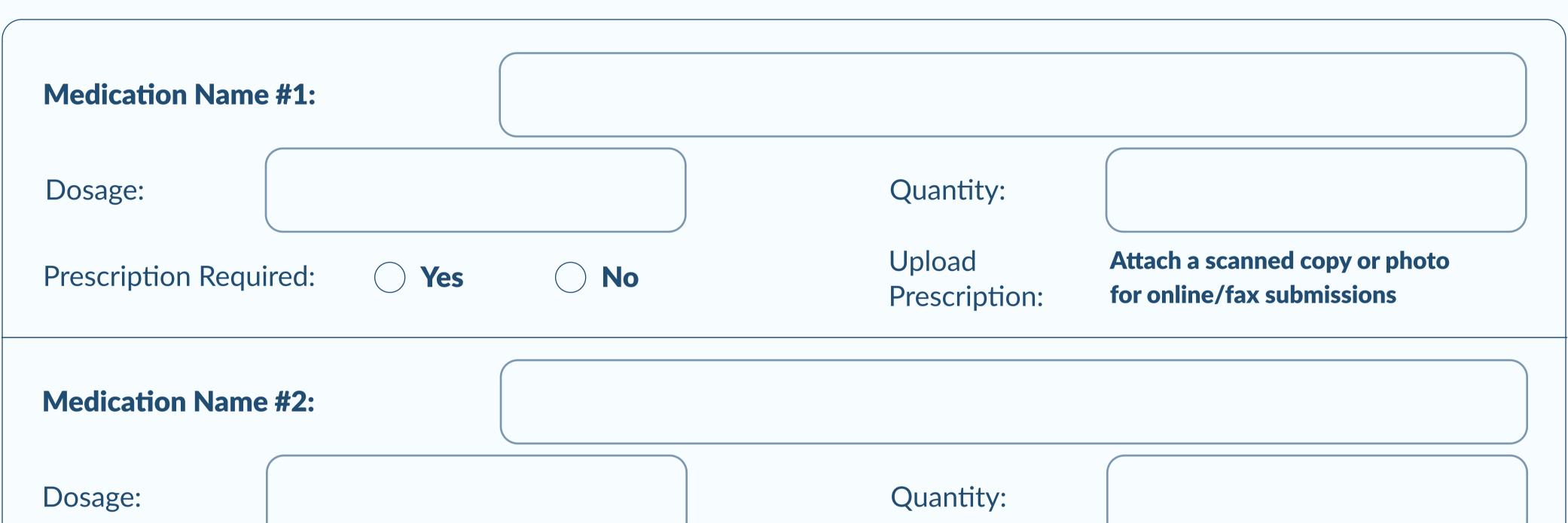
Patient Information First Name: Last Name: Date of birth: Gender: Phone Number: Email Address:

Shipping Address-



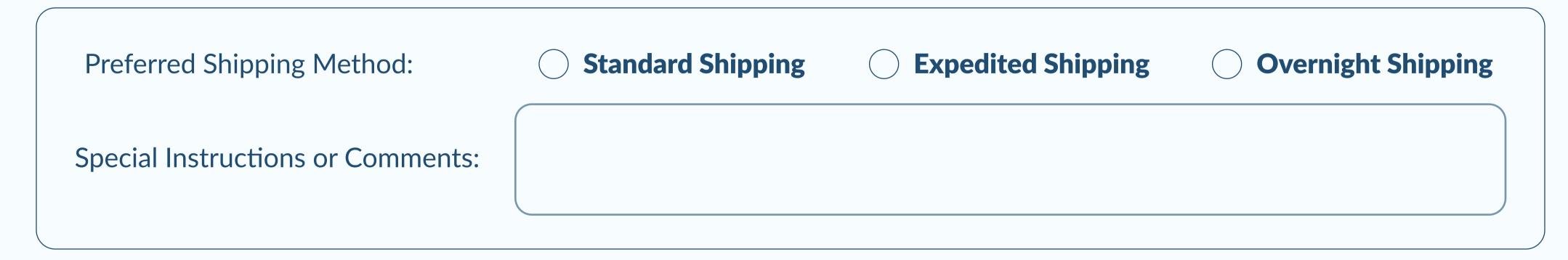
Please make sure to include your house number and any other necessary details to ensure successful delivery.

Medication Information



Prescription Required: Yes	No	Upload Prescription:	Attach a scanned copy or photo for online/fax submissions
Payment Information			
	Payment Method:	Credit Other	
Cardholder Name:		Card Number:	
Expiration Date:		CVV:	
Billing Address			
Same as Shipping Address: O Yes	No	Country:	
State/Province:		City:	
Zip/Postal Code:		Street Address:	

Additional Information



Consent and Verification

Agreement: I confirm that the information provided is accurate. I understand that prescription medications require a valid prescription. I consent to the use of my personal data for the purpose of processing this order.					
Signature:	Date:				