MEDICAL DEVICE AUTHORIZATION FORM

Phone: 800.477.7766 **Fax:** 866.290.3389
Mail: 1340 Russell Cave Road, Lexington, KY 40505
E-mail: id@galls.com

Thank you for your interest in purchasing Medical Devices from North American Rescue, LLC. A "Medical Device" is classified as a device which requires direct supervision by a medical practitioner and/or a label which may be associated with the product reflecting "Caution or RX Only". In order to process your request in a timely manner, the following information is required. Signing and submitting this form allows your organization to purchase Medical Devices under the supervision of a medical practitioner.

CUSTOMER NAME: _____ **DATE:** _____

ORDER NUMBER: _____

SHIPPING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PEOPLE AUTHORIZED TO PURCHASE ON BEHALF OF YOUR AGENCY

NAME	**NAME**
E-MAIL	**E-MAIL**
PHONE	**PHONE**
NAME	**NAME**
E-MAIL	**E-MAIL**
PHONE	**PHONE**

☐ Check here if additional shipping addresses or people are approved and attach the appropriate information

I, _____ , hereby authorize the above mentioned to purchase Medical Devices from North American Rescue, LLC.

MEDICAL DIRECTOR NAME (PLEASE PRINT)	
MEDICAL DIRECTOR NAME (PLEASE SIGN)	
PHONE NUMBER	
FAX NUMBER	
DATE	
STATE MEDICAL LICENSE NUMBER	**EXPIRATION**

SUBMIT

PLEASE RETURN THIS FORM AND A COPY OF THE STATE MEDICAL LICENSE VIA FAX, E-MAIL* OR MAILING ADDRESS ABOVE

NOTE

It is the agency's responsibility to maintain this information and provide current license information as expiration dates draw close or changes occur