



"The Wellness Store"

www.rutlandpharmacy.com 75 Allen Street Rutland, VT 05701

Toll Free 1-800-585-2545 Toll Free Fax: 1-888-724-2545
Local 802-775-2545

THE RUTLAND PHARMACY IS HIPAA COMPLIANT AND THIS INFORMATION WILL NOT BE SHARED WITH BRS.

INSTRUCTIONS:

Today's Date _____

- Carefully complete and return this form before ordering your prescriptions. Please print.
- NEW PRESCRIPTIONS:** You may mail your new prescriptions to Rutland Pharmacy – 75 Allen Street – Rutland, Vermont 05701. Your physician may fax a prescription to 1-888-724-2545 or may call 1-800-585-2545.
- REFILLING A PRESCRIPTION:** If your prescription has already been filled at least once by us, you may order refills by: Completing a refill request at www.rutlandpharmacy.com, **OR** email a request to rutpharm@sover.net **OR** fax a request to 1-888-724-2545 **OR** call us toll free. Please follow with a faxed form so we may have your signature on file.
- TRANSFERRING A PRESCRIPTION:** If you would like a prescription filled that you have on file at another pharmacy, simply complete a Prescription Transfer form.

I do not want child resistant containers. Sign if applicable: _____

Employee Information

Employee				
Last	First	Date of Birth	Gender	M F
Address		Social Security Number		
Allergies (If none, write none and initial)				

Dependant Information

Spouse				
Last	First	Date of Birth	Gender	M F
Allergies (If none, write none and initial)				
Dependant				
Last	First	Date of Birth	Gender	M F
Allergies (If none, write none and initial)				
Dependant				
Last	First	Date of Birth	Gender	M F
Allergies (If none, write none and initial)				

Your employer: _____

SHIPPING AND BILLING INFORMATION

H.S.A. DEBIT CARD NUMBER _____ CVV# ON BACK OF CARD _____ Exp Date _____

Back-up Credit Card Number _____ Type of Card (Circle) Master Card VISA AMEX DISC

Name as it appears on your Card _____ Your Signature _____ Exp Date _____

SHIP TO:

Name _____ Street Address _____

City _____ State _____ Zip _____ Telephone _____