EOR Prescription
Medication Authorization

Med ID #	**Record #**	**Date:**
Last Name:	**First Name:**	**Middle:**
Date of Birth	**Phone:**	

EOR staff may only administer medication according to label instructions, and/or signed doctor's orders.

Medication	RX #	Dosage	Route	Time(s) Given or PRN	Permission to Self-Administer

Signature of Physician: _____ Date:_____

Name of Prescribing Physician:_____

Signature of EOR Managing Employer/Representative:_____ Date:_____