Office of Graduate Medical Education
601 Elmwood Avenue, Box 601G
Suite G-7654
Rochester, NY 14642
Phone 585.275.4607
Fax 585.473.5694

TO: SMH Incoming Residents and Fellows

FROM: Outpatient Pharmacy Staff
Department of Pharmacy

Please print and sign your name below.

This will allow us to identify your signature and printed name, possibly preventing anyone from forging your name on a prescription blank. It will also serve as your authorization for substitution on prescriptions according to our formulary. This information is for our use only.

Please return this form to the Graduate Medical Education Office, Box 601G.

Thank you.

YOUR PRINTED NAME:____

YOUR SIGNATURE:____

DATE:___________________________

2/03