Rx Card Services

Phone: 1-866-266-9955
Fax: 1-855-716-9505
Email: info@ecprx.com

Personal Information

Full Name (please print clearly) ◯ Male ◯ Female

Street Address

City | State/Province | Country | Zip/Postal Code

( ) Phone (Home) | ( ) Phone (Other)

Email | Birthdate (MM/DD/YY) / /

Agent Code

Please check if you are placing this order for a pet.
◯ **Cat** ◯ **Dog** ◯ **Other** (Please specify) _____

Would you like to receive a call to remind you of future refills? ◯ **Yes** ◯ **No**

Medication

For medication(s) that you wish to order, please enter the quantity, and listed price, as obtained through our website or customer service center. An original prescription from your doctor's office is required (mailed, emailed or called in from your Doctor). **PRICING IN $US DOLLARS.**

GENERIC OK?	MEDICATION	STRENGTH	QTY	PRICE
			SHIPPING:	**FREE**
			TOTAL:	

Payment Options

Credit Card ◯ Visa ◯ MasterCard (We do not accept Discover or American Express)

Cardholder's Name

Cardholder's Address

City | State/Province | Country | Zip/Postal Code

Credit Card Number

Credit Card Expiry (MM/YY) / | CVV Code

OR

Personal Checking Account

USA/Canada Only

◯ **I will make a payment by check, and mail it to**

Rx Card Services
24 Terracon Place
Winnipeg, Manitoba
R2J 4G7 Canada

First Time Patients please fill out this section if you are a first time patient, or to update your information.

Secondary Contact

Full Name of Secondary Contact

Relationship To You | ( ) Phone Number

Your Physician

Primary Physician's Name

Clinic Name, Street Address

City | State/Province | Country | Zip/Postal Code

( ) Phone Number Ext. | ( ) Fax Number

Allergies

Do you have any known drug allergies? ◯ **Yes** ◯ **No** If yes, please enter the drug(s) you are allergic to:

Medication, OTC, Herbal Products You Are Currently Taking

(only list medications you are not ordering)

MEDICATION	DOSAGE	FREQUENCY

Referral Program (complete to earn credits for yourself and the person who referred you)

Full Name of person who referred you | ( ) Phone Number

Patient Authorization (Please Check One)

Universal Fulfillment™ operates a marketing and call centre business in Winnipeg, Manitoba, Canada, specializing in the business of assisting pharmacies both within Canada and internationally pursue international prescription service pharmacy. The following terms and conditions govern the sales as between the Universal Fulfillment™ authorized dispensary (the "Pharmacy") and the individual (the "Patient") regarding the products and services (the "Products") offered for sale by the Pharmacy. The Patient herein represents to the Pharmacy that,

◯ "I am over the age of majority, and:

1. I have fully and accurately disclosed my personal information and personal health information and consent to its use by the Pharmacy. I have had a physical examination by a physician within the last 12 months, and do not require a physical examination.

2. I understand that all Products shall be sold & dispensed by a Pharmacy operating within a unique international jurisdiction and in a manner consistent with the laws of that jurisdiction.

3. I authorize and appoint the Pharmacy, as my attorney and agent, to take all steps, sign all documents and to act on my behalf as if I were personally present and acting myself for the limited purposes of (a) obtaining a valid prescription for any prescription which I have sent the Pharmacy; and (b) packaging my prescriptions and delivering them to me. This authorization shall include, but not be limited to: collecting and using my personal and personal health information as reasonably necessary for the fulfillment of my order, including disclosure to a licensed physician if required for the issuance of a valid prescription in the jurisdiction of the Pharmacy. This authorization may be revoked at any time and shall continue until I revoke it.

4. I understand that the Pharmacy is legally incorporated and authorized by law to carry on business in the jurisdiction of the Pharmacy, and that I am purchasing medications that have been approved for sale in the jurisdiction of the Pharmacy. Title to my medications passes from the Pharmacy to me in the jurisdiction of the Pharmacy when my medications leave the Pharmacy. All agreements reached or contracts formed with the Pharmacy shall be deemed to be made in the jurisdiction of the Pharmacy, the laws of the jurisdiction of the Pharmacy shall govern all transactions, and I attorn to the courts of the jurisdiction of the Pharmacy, which shall have sole and exclusive jurisdiction over any dispute arising between me and the Pharmacy, its affiliates, officers and directors.

I HAVE READ AND UNDERSTAND THESE TERMS AND AGREE THAT THEY SHALL BE BINDING UPON ME AND MY ASSIGNS, HEIRS AND PERSONAL REPRESENTATIVES."

OR

◯ "I am the parent/legal guardian/power of attorney for the Patient disclosed herein, am over the age of majority, and have full authority to sign for and provide the above representations to the Pharmacy on the Patient's behalf."

Patient's Signature | / / Date (MM/DD/YY)

PSC: | MKT: WEB | AFF: RCS-100