

Committee on Rehabilitating Impaired Pharmacists  
Sponsored by the Alabama State Board of Pharmacy  
10 Inverness Center Parkway  
Birmingham, Alabama 35242

## VERIFICATION OF PRESCRIBED MEDICATION

**NOTICE TO PRESCRIBING PRACTITIONERS:** RE: \_\_\_\_\_  
NAME OF PHARMACIST, INTERN OR TECHNICIAN

To the practitioner of the Alabama Board of Pharmacy Monitoring participant;

The individual who is providing this form is a participant in the Alabama Board of Pharmacy Monitoring Program. As part of the program, the pharmacist, intern or technician is to provide documentation of all prescribed medications.

Please take a few minutes to complete the form below. After completing the form, please mail it to the program office at the address listed above. **The practitioner must mail the form.** If you have any questions, please call the program staff at the following telephone number: Steve Moore, Program Administrator (205) 975.8548.

## PRESCRIPTION INFORMATION

Date of Prescription	Type of Medication	Quantity and Dosage Prescribed/Number of Refills	Reason for Medication

I acknowledge that my patient has informed me that he/she has a \_\_\_\_\_ problem.

\_\_\_\_\_  
Name (Please print)

\_\_\_\_\_  
Practitioner Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Telephone Number