Request for Prescription Drug Override

Faculty, Staff, Retiree

Patient Information:

Name (Please Print)	Social Security Number	Date of Birth

Address & Phone:

Street	City	ST	Zip

Home Phone	Work Phone

Required Information:

Duration of Travel:

From: _____ Until: _____

Reason for Travel:

☐ Vacation ☐ Sabbatical ☐ Other (please explain: _____)

Prescription Information:

Medication Name and dosage	Normally Obtained by: Mail-Order	Pharmacy
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Would you prefer to receive your override via:
☐ Mail-Order
☐ Pharmacy

If pharmacy, please provide the following information for your pharmacy of choice:

Name: _____

Address: _____

City, ST Zip: _____ Phone: _____

PLEASE NOTE: The override will be put in place and the pharmacy will be able to fill your prescription 5 days prior to your departure. Please plan to pick-up your prescription within that timeframe.