



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
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

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.