TALON
COMPOUNDING PHARMACY

Physician/Practice Information

All information is required. Please complete entirely.

Physician:_____

DEA#:_____ DPS#:_____

Specialty:_____

Name of Business/Clinic:_____

Address:_____

_____

Phone #1:_____

Phone #2:_____

Fax #:_____

Email:_____

POC (Point of Contact)_____

Authorized agents who may place orders (name/title):

_____ RN LVN NP PA DO MD Other:_____
_____ RN LVN NP PA DO MD Other:_____
_____ RN LVN NP PA DO MD Other:_____
_____ RN LVN NP PA DO MD Other:_____

Thank you for your cooperation in helping us maintain our compliance with the Texas State Board of Pharmacy. Let us know how we can better serve you and your patients.

Physician Signature:_____ Date:_____

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