RX PHARMACY & COMPOUNDED PRODUCTS INC.
1-B 2665 HENDERSON HWY. EAST ST. PAUL, MB, R2E 0K7
PHONE: 204-306-4445 | FAX: 833-536-1732

PAYMENT AUTHORIZATION FORM

Pharmacy Name: _____

Credit Card (Please Check one)

- ☐ VISA
- ☐ MASTERCARD

Name on Credit Card: _____

Credit Card #: _____

Expiration Date: _____

Security Number (3-Digit): _____

Agreement must be signed by the Pharmacy Manager or Pharmacy Owner

Title (Owner or Pharmacy Manager) : _____

Signature: _____

Name (Please Print): _____

Date: _____

CHANGES / CANCELLATIONS CANNOT BE MADE TO AN ORDER ONCE SUBMITTED

FREE CITY WIDE DELIVERY
MINIMUM 5 DICLOFENAC ORDERS FOR FREE SHIPPING

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PHONE: 204-306-4445 | FAX: 833-536-1732

Rx Pharmacy & Compounded Products Inc. Agreement:

_____ (pharmacy name, further reference to as “the pharmacy”) licensed in the Province of Manitoba by the College of Pharmacists of Manitoba. Pharmacy License # _____

Pharmacy Address: _____

Telephone #: _____ Fax#: _____

-and-

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PHONE: 204-306-4445 | FAX: 833-536-1732
Pharmacy license: 35839

"The pharmacy" consents to the externalization of compounding services for non-sterile extemporaneous products by Rx Pharmacy and Compounded Products. These services will adhere to the guidelines and regulations established by the College of Pharmacists of Manitoba and Health Canada.

"The Pharmacy" acknowledges that payment for the products and services rendered by Rx Pharmacy & Compounded Products will be conducted through a credit card, as specified in a separate credit card authorization form.

Signature (as per pharmacy): _____
Name (as per pharmacy): _____

Signature (RX Pharmacy & Compounded products): _____
Name (Rx Pharmacy & Compounded Products): _____

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