**Overdose Prevention Initiative**
**Bureau of Alcohol & Drug Use Prevention, Care & Treatment**
**42-09 28th Street, 19th Floor, CN14, Long Island City, NY 11101**
**Tel 347.396.7133 I Fax 347.396.8974**

# Supplies Order Form

The undersigned individual represents and warrants that he/she is a medical practitioner licensed in the state of New York to prescribe products determined by the FDA to carry the Federal Legend and that he/she maintains a bona fide practice at the address listed below. (Caution: Federal Law restricts the drug or device to be sold or dispensed by or on the order of a physician or other licensed practitioner.)

Clinical Director Program Director Program site

Delivery address City State Zip

Phone number Email address

I certify that the information provided in this verification is true and accurate.

_____
Clinical Director Signature License # Date

*Remember to order 2 doses of naloxone and 2 atomizers for each overdose kit!*

| Item | Description | # on hand | Identification number | Expiration date | # of items requested |
|---|---|---|---|---|---|
| Naloxone | Luer-lock prefilled syringe of Naloxone HCl 2mg/2mL | | (Stock #) | | |
| Atomizer | Mucosal Atomization Device Wolfe-Tory Medical | | (Lot #) | | |

_____
Signature of approval Date
DOHMH Overdose Prevention Initiative staff

(*DO NOT WRITE BELOW THIS LINE: **FOR PHARMACY USE ONLY***)

**PHARMACY:** ***Please complete and fax to Lara Maldjian at 347-396-8974***

Date order form received Received by

Date order shipped to program site

| Item | Quantity | Stock number (naloxone)<br>Lot number (atomizer) | Expiration date |
|---|---|---|---|
| Naloxone | | | |
| Atomizer | | | |

Date order received at program site