Save this form to your computer. Fill it out completely and email to……medicare4us.com@gmail.com

MEDICATION LIST						
Client's Name / Year				Zip Code / COUNTY		
COMPLETE NAME OF MEDICATION (Doxycycline monohydrate)	DOSE (50 mg OR 50 mcg OR 4 Pens) etc	FREQUENCY (1 per day or 4 per week) etc	NUMBER OF MEDS / FREQ OF REFILLS (60 tabs/ month or 12 pens/ 3 months)	Pick 1st Pharmacy	Pick 2nd Pharmacy	Pick 3rd Pharmacy