

DRUG

DRUG

REFILL NO.

REFILL NO.

Customer's Order No. \_\_\_\_\_ Date \_\_\_\_\_ 19\_\_

Customer's Order No. \_\_\_\_\_ Date \_\_\_\_\_ 19\_\_

Name \_\_\_\_\_ Tel \_\_\_\_\_

Name \_\_\_\_\_ Tel \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

TAKEN BY \_\_\_\_\_ FILLED BY \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

CASH C.O.D. CHARGE ON ACCT. WILL CALL DELIVER

TAKEN BY CASH C.O.D. CHARGE ON ACCT. WILL CALL DELIVER

QUAN. DESCRIPTION PRICE AMOUNT

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TAX TOTAL  
RECEIVED BY

TAX TOTAL  
RECEIVED BY

All claims and returned goods MUST be accompanied by this bill.

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