USC PHARMACIES'
Prescription Delivery Application

PATIENT INFORMATION

Name:		
Date of birth:	Phone:	Email:
On Campus address for delivery:		

PERSON MEDICATIONS CAN BE DELIVERED TO OR LOCATION MEDICATION IS TO BE DELIVERED

PLEASE NOTE ALL DELIVERIES REQUIRE SIGNATURE UPON DELIVERY, AND WILL NOT BE LEFT UNATTENDED
(YOU MUST CALL TO NOTIFY THE PHARMACY PRIOR TO EACH DELIVERY REQUEST)

Name:	Location:

MEDICATIONS TO BE DELIVERED (PLEASE CHECK ONE)

□ I would like all my medications at USC Pharmacy or USC Medical Plaza Pharmacy to be delivered.

□ I would like to specify my delivery preference on each order

□ I would like to exclude the following medications from delivery:

SIGNATURES

I authorize the verification of the information provided on this form as to my credit and authorize USC Campus Pharmacy to charge on the indicated credit card for the medications indicated above. I have received a copy of this application.

Signature of applicant:	Date:

Please note for the privacy of our patients, our delivery bags will not have any indication of the name of the medications, only name of the individual

---

CREDIT CARD PAYMENT INFORMATION*

Name on credit card:		
Billing address:		
City:	State:	Zip Code:
Credit Card (Circle one): VISA MasterCard American Express Discover FSA		
Credit Card Number:		
Expiration Date:	CSV:	

*credit card information will be shredded after entry into secured database