



Employee Program

CanaRx Employee Enrollment Form

MEMBER #:

FAX DIRECTLY FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION(S) TOLL FREE TO: 1-866-715-(MEDS)6337 OR

MAIL TO: AmherstMeds, P.O. BOX 44650, DETROIT, MI., U.S.A. 48244-0650 PHONE TOLL FREE: 1-866-893-(MEDS)6337

PATIENT INFORMATION:		Birthdate _____ DD/MM/YYYY	<b>NOTE:</b> Please request a <b>3-month</b> supply of medication with <b>3 refills</b> .  <b>New-to-you</b> medications must be domestically prescribed, filled and taken for a period of no less than 30 days.
Phone (Home)	Phone (Work)		
First Name (please print)	Initial	Last Name	
Street Address			
City/State		Zip Code	

List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements.	Strength	Reason for Taking	Daily Use
<i>Ex. Lipitor</i> (This is NOT a prescription.)	<i>Ex. 10 mg</i>	<i>Ex. Cholesterol</i>	<i>Ex. One a day</i>

**MEDICAL HISTORY** (If you require more space, please attach a separate piece of paper.)  Male  Female

(i) Operations: eg. Hysterectomy, Gall Bladder, Heart Operations, etc. \_\_\_\_\_

(ii) Hospitalization: (stays in hospital past 5 years) \_\_\_\_\_

(iii) Present Illness: (ongoing) eg. Diabetes, Heart Disease, Osteoporosis, etc. \_\_\_\_\_

(iv) Drug Allergies:  NO  YES If yes, please specify: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Signature: (optional) \_\_\_\_\_ Date: (DD/MM/YY) \_\_\_\_\_

**AUTHORIZATION**  
 I confirm that a U.S. Physician will regularly monitor me and that I have had a physical examination within the past 12 months. I verify that I have taken the medications ordered through this program for a period of more than 30 days. I certify that I have read, understand and agree to the terms of agreement on the reverse and that the information provided by me is accurate and true.  
 I request and authorize the Town of Amherst, MA, to pay for any and all services, fees and amounts relating to the prescription medications that I will obtain through this service.

Patient Signature: \_\_\_\_\_ Date: (DD/MM/YY) \_\_\_\_\_