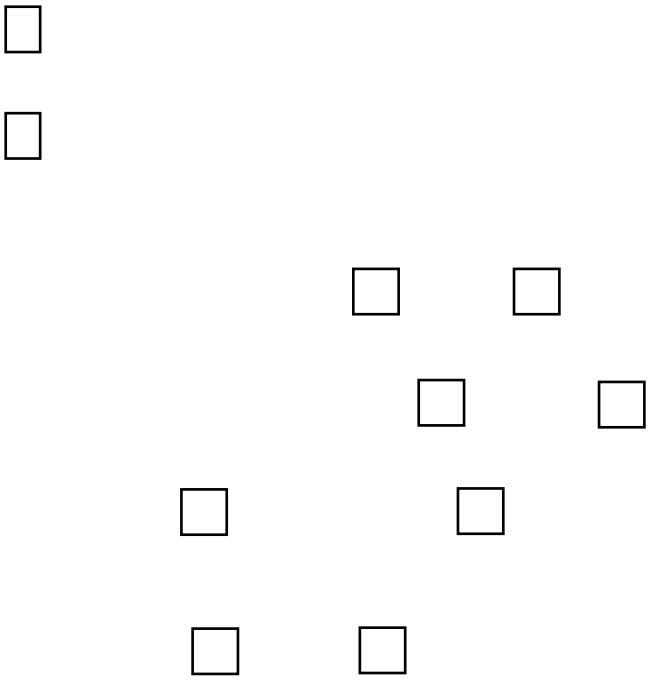

, Q M X U H G : First Fill Prescription Form

Employee Name:

Date of Injury: _ DOB:

Injured Worker Instructions

On your first Pharmacy visit, please give this notice to any pharmacy listed on this insert. This will H [S H G L W H U R V H