# SCENAR PRESCRIPTION FORM

Please print out this form, complete the top portion, have your Health Care Provider (Medical Doctor, Chiropractor, Dentist, Podiatrist, Nurse Practitioner, Physicians Assistant, Ph.D., Physical Therapist, Doctor of Acupuncture or Doctor of Osteopathy) sign it and mail or fax it in today.
THIS FORM REQUIRED FOR USA ORDERS ONLY!

**(Please Print)**

**Patient's Name**______________________________________________

**Address** ______________________________________________

**City** __________________ **State** _________________ **Zip** _________

**Day Phone**____________________**Evening Phone** _________________

**E-mail**________________________**Fax** _______________________

**Signature** ______________________________________________

**Units prescribed:** ______________________________________

**Name of your licensed health care practitioner**

________________________________________________________

**License #** ______________________________________________

**Dr's address** ______________________________________________

**City**___________________**State**________________**Zip** __________

**Doctor's Signature** _________________________________________

**Print out and mail/fax form to:**

**TOMATEX LLC**
**Info@Tomatex.com**
**www.Tomatex.com**

**Fax 817-402 2037**