Alabama Dental Wellness Committee

Michael C Garver, DMD Director

Email to:mcg1309@gmail.com

VERIFICATION OF PRESCRIBED MEDICATION

NOTICE TO PRESCRIBING PRACTIONERS: **RE**:_____
NAME OF Dental Professional

To the practitioner of the Alabama Impaired Dental Professionals Monitoring participant;

The individual who is providing this form is a participant in the Alabama Impaired Dental Professionals Monitoring Program. As part of the program, the dental professional is to provide documentation of all prescribed medications.

Please take a few minutes to complete the form below. After completing the form, please email this document and retain a copy for your records. If you have any questions, please call the program staff at the following telephone number: Mke Garver, DMD 251-866-5585.

PRESCRIPTION INFORMATION

Date of Prescription	**Type of Medication**	**Quantity and Dosage Prescribed/Number of Refills**	**Reason for Medication**

I acknowledge that my patient has informed me that he/she has a _____problem.

_____ _____
Name (Please print) Practitioner Signature

_____ _____
Address Date

_____
Office Telephone Number