Board of Dental Examiners of Alabama

Alabama Dental Professionals Wellness Committee
Michael C. Garver, DMD, Director

VERIFICATION OF PRESCRIBED MEDICATION

REF:_____
Name of Dental Professional (Printed)

ATTENTION: Practitioner prescribing to the above-named dental professional

The above-named dental professional is a participant in the Alabama Dental Professional's Wellness Program. He/she is providing this form to you to verify and document any/all medications that you are prescribing as part of your treatment.

Please assist us by completing the form below. Once completed, email a copy to the below email address, and maintain a copy for your records.

Should you have any questions, please contact our program director, Mike Garver, DMD at (251) 605-2883.

PRESCRIPTION INFORMATION

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

By signing below, I acknowledge that the above-named dental professional has informed me that he/she has a _____problem.

Prescribing Practitioner Name:_____

Office Address:_____

Office Phone:_____

_____ _____
Prescriber's Signature **Date**

Email form to: mcg1309@gmail.com