KernMedical

NOTICE OF CONSENT for PHARMACY DELIVERY SERVICE

Kern Medical
Campus & Sagebrush Pharmacies

Instructions:

1) Please read the following form in its entirety. This form must be signed and sent to the pharmacy prior to beginning desk delivery service.

2) The second page is a dependents page, if you would like to have your dependents' prescriptions delivered to your desk as well.

3) Once filled out, please fax pages 2-3 to **661-432-1113** (attention not necessary). Please don't forget to utilize your department's fax cover sheet.

4) If you have any questions regarding the service, please call **661-862-7552**

5) Thank you for using Kern Medical's outpatient pharmacies!

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NOTICE OF CONSENT for PHARMACY DELIVERY SERVICE
(OPT-IN FORM)

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By signing below, I acknowledge and will abide by the following:

1) I understand that the pharmacist-on-duty, in his or her professional opinion, may deny delivery of my medications and instead require me to pick them up at the pharmacy.

2) I understand that I am responsible for the cost of my prescriptions and that payment is due upon delivery. I also acknowledge that the delivery driver can make limited change, cannot accept credit card payments, but may accept personal checks.

3) I understand that if I am not present at my office upon delivery of my medication(s), the driver will wait no more than five (5) minutes before leaving and that my medication(s) will be returned to the pharmacy. Another delivery may be attempted; the pharmacy will notify me if delivery was unsuccessful and a re-attempt may be made at that time.

4) I understand that any medication(s) I receive *cannot be returned to the pharmacy* unless the prescription(s) was/were filled incorrectly, in accordance with California pharmacy law.

5) I understand that the pharmacy will make every effort to prepare my delivery; however, **deliveries are not guaranteed**. If there are any delays, I will be notified as soon as possible. New medications will require me to have the prescription delivered to the pharmacy *prior* to their delivery (faxes and call-ins from my physician are acceptable).

6) I understand that I may also accept deliveries for my eligible dependents. I will list their names and dates of birth on the back of this page. If my spouse is a member of the County POS plan or Legacy, I may also accept prescriptions on his/her behalf but will require their signature on this form.

7) It is my responsibility to check with my immediate supervisor that having my medication(s) delivered to my office is approved by him/her.

Name (print): _____ Signature: _____

DOB: _____

Spouse (print): _____ Signature: _____
(if picking up prescriptions for spouse; see #6 above)

Date: _____ DOB: _____

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DEPENDENTS PAGE

Please list each dependent's name and date of birth on this page.
If your child is 18 years or older, please have them fill out their own Consent Form.
Thank you.

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

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