**Request for Supply of Section 29 Products**

PLEASE NOTE: REQUESTS FOR SECTION 29 PRODUCTS MUST BE ON THE LATEST ISSUE OF THIS FORM. TO ENSURE RAPID ORDER PROCESSING, ALWAYS REQUEST A NEW FORM FROM HEALTHCARE LOGISTICS BEFORE PLACING EACH NEW ORDER.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **To:** | (HCL Customer Service Rep) | | **Email:** [orders@healthcarelogistics.co.nz](mailto:orders@healthcarelogistics.co.nz) | |
| **HCL Sold-to Account #** | |  | **HCL Ship-to Account #** |  |
| **Name:** | |  | **Name:** |  |
| **Address:** | |  | **Address:** |  |
| **City:** | |  | **City:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Product (name, dose form and strength)** | **Quantity** | **Doctor Name** | **Patient Name** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| *NOTE: Where a supplied order form contains the information required above, the section above does not need to be completed if the order is attached to this form.* | | | |

|  |  |
| --- | --- |
| DECLARATION: Please select one and sign below | Tick one |
| I confirm that I am authorised under Section 29 of the Medicines Act 1981 to request supply of the above named medicines. I am a registered medical practitioner or a pharmacist acting on behalf of one. I confirm that I hold any required licenses. |  |
| I represent a hospital and this medicine is required or held for use in an emergency.  Patient / Doctor details are not available at this time. |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name (print)** | **Signed** | | **Date** |
|  |  | |  |
| **Contact Phone Number** | | **Contact Email Address** | |
|  | |  | |

**HCL Use Only**

|  |  |  |  |
| --- | --- | --- | --- |
| **INF-ZPL38 Checked** |  | **S/O#** |  |
| **Keyed By** |  | **Date** |  |
| **Released By** |  | **Date** |  |