Please print clearly

Registration Form

Physician Name: _____

Physician Email Address: _____

State License Number: _____

National Provider Identifier (NPI): _____

DEA License Number: _____

Practice Name: _____

Office Point of Contact (POC): Frank Crowley

POC Email Address: fcrowley@admhs.org

Primary Address: _____

_____

Primary Phone: (805) **Back Line:** ( ) _____

Primary Fax: (805) _____

Average Scripts /Week: _____

Name of Practice Management System: _____

PLEASE INCLUDE COPY OF VALID DEA CERTIFICATE WITH THIS FORM

Physician Signature Box: PLEASE KEEP SIGNATURE IN BOX Date: _____

_____*Verified (RxNT Internal Use Only)*

1449 Whitehall Road, Annapolis, MD 21409
Phone: 1-800-943-7968 ext. 7033 Fax: 410-670-7178 Email: mrodriguez@rxnt.com