Medicine Information Form

Please PRINT, complete and mail this form along with a $5 processing fee for Each medication requested to : **Free Medicine Program, PO Box 630217, Miami, FL 33163-0217**.
If you have any questions please call (800) 921-0072. Please type or Print clearly :

Patient's Name:		
Address:		
City:	State:	Zip
Phone:	E-mail Address: (if available)	

Name of your Medicine	Doctor's Name & Address
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Number of medications_X $5 each = Amount Due $

Please make checks payable to "**Free Medicine Program**"
No application(s) can be processed without the appropriate fee enclosed.