**PHYSICIAN AUTHORIZATION FOR MEDICATION SUPERVISION**

Per CBRF regulations, ARP requires physician authorization to supervise all patient's medications (including prescription and non-prescription).

Please note the medications below and sign.

_____ is currently taking the following medications.

| MEDICATION | DOSE | FREQUENCY |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Thank you for your cooperation.

Physician's Signature: _____ Date: _____

The above signature authorizes *Insert Organization name* and its agents to supervise this patients' medications unless otherwise indicated.