

**Please include this form for OTC medications purchased after 1/1/2011  
or any dual purpose item that requires a letter of medical recommendation**

This form should be completed by your physician. All fields in the appropriate section must be completed. Use additional sheets if necessary. Unless otherwise noted by your physician, this form will expire after 1 year.

**Please provide the following information (please print clearly)**

Employee Name: \_\_\_\_\_

Employee ID: \_\_\_\_\_

Employer Name: \_\_\_\_\_

**Prescribed Over the Counter Medications**

**List the specific prescribed over the counter medications:**

\_\_\_\_\_

Effective Date for prescribed OTC: \_\_\_\_\_ Duration Date for prescribed OTC: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Dual Purpose Items** (e.g. Massage Therapy, Weight Loss Programs, Nutritionist Expenses)

**Describe the diagnosed condition being treated:**

\_\_\_\_\_

**Describe the specific recommended treatment:** If vitamins/supplements are being recommended, your physician must specify each individual supplement needed to treat the medical condition listed.

\_\_\_\_\_

**Indicate the duration of treatment:**

\_\_\_\_\_

This treatment is recommended to treat the medical condition referenced above. This treatment is not for general health purposes, to improve the appearance or for cosmetic services.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_