ECU PHARMACY SERVICES
REGISTRATION for DELIVERY

Name: ______ Date of Birth: ______

Home Address: ______ City: ______
State: ______ Zip: ______

Home Phone: ______ Work Phone: ______
Email Address: ______
Allergies: ______
Insurance - Attach a copy of insurance card if possible
Insurance ID: ______ Group #: ______ Bin #: ______

Must Check One:
☐ Others can sign for deliveries on my behalf
☐ I prefer to sign for all deliveries

Fax: 252-744-1800
Phone: 252-744-2721

Additional Family Members (Call or Email Pharmacy with Family Members Allergies):

Name	Date of Birth	Relationship

ECU Delivery Address: ______

Indicate whether you prefer to call & request delivery or to have ECU Pharamacy Services automatically deliver when a prescription is phoned in by a provider or a refill is requested through any automated service or by phone. Note: The ECU Pharmacy Services delivery personnel cannot take back medications once accepted.

Automatically Deliver ☐ I will call and request delivery ☐

My signature below authorizes ECU Pharmacy Services to charge the credit/debit card, also provided below, for my prescription purchases and to deliver my prescriptions to the address provided above following the date on this form. I also understand that the debit/credit card information I provided will be physically stored on site and will be destroyed securely upon one of the following: my request to terminate delivery, providing a revised form or upon expiration of this form which is one (1) year from today. It is my responsibility to submit a new registration form to ECU Pharmacy Services if I desire to update/change anything on this form. It is also my responsibilty to notify ECU Pharmacy Services in writing if I desire to terminate services altogether.

Credit/Debit Card Number: ______ Exp Date ______
Security Code on Back: ______
Name as it appears on card: ______

Signature: ______

Date: ______