



**Office Practicum™**  
Pediatric Solutions

### PROVIDER AGENT AGREEMENT

I hereby affirm that except as set forth in this paragraph, that I am an authorized representative of the below practice, and that our prescribers/providers will prescribe and order medications using the user identifier and password(s) provided to us by Connexin Software. Provider Agent(s), in addition to our Prescriber(s), can use Office Practicum to order medication that our Prescriber(s) prescribe for patients who are under our care. Such person(s) will be acting pursuant to our express written instructions and we agree that we are solely responsible for insuring that adequate documentation exists verifying the prescribing physician(s) and that such documentation will be provided to the pharmacy dispensing such medication, and/or Connexin Software, if requested.

**Once completed fax to; Attention Registration at Fax # 267-960-2753**

**\*\*PLEASE PRINT LEGIBLY**

PRACTICE NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE #: \_\_\_\_\_

#### AUTHORIZING PROVIDER(S):

Date	Name	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____

#### PROVIDER AGENT(S):

Date	Name	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____