 \_ Prescriber’s signature

Name

…………………………………………………………………………………………………… DOB …….………………………………………………………………………………………

Address

……………………………………………………………………………………………………

……………………………………………………………………………………………………

**Date:**

**Patient details: ……………..**

Podiatry Board of Australia**- Registration No: xxx**

 Full Name

**Podiatric Surgeon Endorsed for Scheduled Medicines**

Address: Insert Address: Insert Phone: 12 3456 7890

Fax: 12 3456 7890

**PRESCRIPTION**