



**DEPARTMENT OF VETERANS AFFAIRS  
NEBRASKA-WESTERN IOWA HEALTH CARE SYSTEM**

Omaha  
4101 Woolworth Avenue  
Omaha NE 68105-1873

Lincoln  
600 S 70<sup>th</sup> Street  
Lincoln NE 68510-2493

Grand Island  
2201 N Broadwell Avenue  
Grand Island NE 68803-2196

**To: Incoming Medical Providers**

**From: Pharmacy Service**

**Subject: We need the following Physician Signature card completely filled out in order to provide prescriptions through the VA system.**

**Please be advised that we have a closed formulary. You can access our formulary on the following web site: <http://formularyproductions.com/visn23/>**

**Pharmacy Signature Card**

**Licensee Name :**

<b>Licensee Address: (Office)</b>	VA Nebraska Western Iowa Health Care System
<b>(circle one)</b>	Omaha          Lincoln          Grand Island          CBOC _____
<b>Office Phone:</b>	
<b>Office Fax:</b>	
<b>Provider Pager Number:</b>	

**Duty Status (circle one)    Resident          Fellow                                  VA Staff                                  Contract**

<b>License Type (Degree):</b>	<b>Service Line (Speciality):</b>
<b>DEA Number:</b>	<b>DEA Expiration Date:</b>
<b>Social Security Number:</b> (required by Dept of Veteran's Affairs)	<b>License Number :</b>
<b>NPI Number:</b>	<b>Sex-Please Circle:    Male                  Female</b>

<b>Signature:</b>	<b>Date:</b>
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<b>ONLY Residents/Fellows:</b>	<b>Indicate (circle) anticipated expiration of service date</b>				
<b>1 year</b>	<b>2 years</b>	<b>3 years</b>	<b>4 years</b>	<b>5 years</b>	

**This is an official signature. Any other variations will not be accepted**

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