



TEXAS DEPARTMENT OF PUBLIC SAFETY

Prescription Information Transmittal Form

Date _____

PHARMACY INFORMATION

Texas DPS Number _____ Federal DEA Number _____

Pharmacy Name _____

Pharmacy Address _____

City/Zip Code _____ Telephone Number _____

TRANSMISSION

Disk Tape Other _____

File Name _____ Total No. of Transactions Included _____

Beginning Prescription Date _____ Ending Prescription Date _____

Authorized Signature _____ Print Name _____

**MAIL TO: ATLANTIC ASSOCIATES INC
PRESCRIPTION COLLECTION
8030 S WILLOW ST
MANCHESTER NH 03103**



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