

# PHYSICIAN SAMPLE RECEIPT

Date: \_\_\_\_\_

Territory #: \_\_\_\_\_

Name of Licensed Practitioner: \_\_\_\_\_ ☐ DEA # or ☐ State License #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature of Licensed Practitioner: \_\_\_\_\_

Product Name	Package Size	Lot Number	Qty.	Product Name	Package Size	Lot Number	Qty.
<b>Nestabs®</b>				<b>ProCort®</b>			
50967-219-02	1 x 12 Samples			50967-357-02	1 x 5 Samples		
50967-219-90	1 x 90			50967-357-60	1 x 1		
<b>Nestabs® DHA</b>				<b>Fem pH™</b>			
50967-317-02	1 x 18 Samples			00813-799-55	1 x 1		
50967-317-30	1 x 30						
<b>Nestabs® ABC</b>				<b>Urogesic Blue®</b>			
50967-309-02	1 x 12 Samples			0485-0151-25	1 x 25		
50967-309-30	1 x 30						
<b>Irospan® 24/6</b>							
50967-126-02	1 x 12 Samples						
50967-126-30	1 x 30						



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