Power of Attorney DEA Authorized Receiver Form

Date:

Registrant Name:

DEA Registration Number:

Facility Name:

Address:

City:

State:

Zip / Postal Code:

Contact Name:

Phone Number:

Email Address:

The following individuals are authorized to receive and sign for shipments.

Name:	Name:
Name:	Name:
Name:	Name:
Name:	Name:
Name:	Name:

It is the responsibility of the Registrant to notify VistaPharm of any changes to this list as soon as possible.