MIDWEST OPERATING ENGINEERS
FRINGE BENEFIT FUNDS

Medication Printout Request

Today's Date:_____

Medical ID #:_____ Phone Number:_____

Requesting a printout for the following dates:

From _____ _____ _____To_____ _____ _____

Month Day Year Month Day Year

For the following people: First & Last Name (PLEASE PRINT)

_____

_____

_____

_____

_____

_____

Address records should be mailed to:

_____ _____

Street Address City State Zip Code

Note: A signature is required for <u>EACH</u> person over the age of 18 years old requesting a medication printout.

Signature:

_____ _____

_____ _____

_____ _____

Please return this form back to the MOE Fringe Benefit Funds Office-Pharmacy Benefit Department, Attention: Tracy