



OFFICE OF LOGISTICS MANAGEMENT (OLM)

e-Portal and MMIS Signature Authorization Form – LM-3P (Pharmacy)

Submit Form:		You must complete this Form On-Line. Hand written Forms will be rejected. Mail, Fax or PDF the entire package to: Fax: 679-1993 or Mail to: MC 2012					
Requester's Name:			Title:				
Department:							
Phone Number:			Fax Number:				
Room Number:			Mail Code:				
Email Address:							
Hospital/Clinical Unit Only:		<input type="checkbox"/> In-Patient <input type="checkbox"/> Out-Patient <input type="checkbox"/> Other:					
Authorized Employee:				Title:			
Telephone #:		Fax #:		Room #			
Mail Code:		Signature:			Date:		
Pharmaceutical Authorization: This employee can order the following pharmaceutical types: Please Initial: Standard: <input type="text"/> Controlled: <input type="text"/>				Special Instructions:			
Authorized By:			Title:				
Authorized Signature: _____ 1. Department Head _____ Typed Name - Mandatory			Date:				
			Telephone #:				
			Fax #:				
Request:		<input type="checkbox"/> Update account information (e.g., Expiration Date, Ship-To Location) <input type="checkbox"/> Add new user and following accounts <input type="checkbox"/> Delete following accounts <input type="checkbox"/> Add following accounts <input type="checkbox"/> Delete user and associated accounts					
Authorized for Accounts:							
Ship-To #	Ship-To Location	FY	Fund	Org	Account	Expiration Date	
For Logistics Management Use Only:							
Signatures:			Date:		Date:		
_____ 1. Pharmacy Director			_____		_____ 2. OLM Financial Officer		
Typed Name - Mandatory			_____		Typed Name - Mandatory		