

ORDER FORM

Medication Usage Evaluation Manager®

USER'S NAME (WILL PRINT ON REPORTS; FACILITY NAME NOT ALLOWED)

FACILITY/HOSPITAL/PHARMACY NAME

ADDRESS

CITY/STATE/ZIP CODE

PHONE/ FAX

E-MAIL ADDRESS WHERE SOFTWARE WILL BE SENT (PLEASE PRINT CLEARLY)

Select the Database Set(s) you want to order (\$269.00 each).

<i>Database Set(S)</i>	<i>Cost</i>	<i>Total</i>
Long-Term Care	\$269.00	_____
Hospital	\$269.00	_____
Psychiatry	\$269.00	_____
Infectious Disease	\$269.00	_____
	TOTAL	_____



Payment Options

MasterCard Visa Purchase Order

Account # _____

Exp Date _____

Mail your check or fax your order to:

Insight Therapeutics, LLC
740 Duke Street
Suite 120
Norfolk, VA 23510
Phone: 757/625-6040
Fax: 757/625-4538

Name on Card _____

Signature _____

Purchase Order No.: _____