Authorization is hereby given to dispense the generic equivalent unless otherwise indicated by the physician

Date	Time	**PHYSICIAN'S ORDERS**
		☐ Admit to Inpatient Status (I certify that inpatient services are needed)
		☐ Place Patient in Outpatient Status
		☐ Place Patient in Outpatient Status and begin Observation Services
Do Not Use Abbreviations: U (for unit), IU (for international unit), Q.D., Q.O.D., Trailing zero (X.0 mg), MS, MSO_4, $MgSO_4$		

I certify by my signature that the ordered level of care is based on medical necessity as documented within this medical record (42CFR Section 456.60 Certification/recertification).

Physician Signature: _____ Date: _____ Time: _____

Print Name: _____

Allergies & Sensitivities ☐ NKA	Weight	Height	Diagnosis

JFK MEDICAL CENTER
Main Campus - Atlantis
North Campus - West Palm Beach
5301 South Congress Avenue
Atlantis, FL 33462

Patient Identification/Label