



Board of Dental Examiners of Alabama

Alabama Impaired Professionals' Committee

Dr. John Bennett, Committee Chair

VERIFICATION OF PRESCRIBED MEDICATION

REF: _____

Name of Dental Professional (Printed)

ATTENTION: Practitioner prescribing to the above-named dental professional

The above-named dental professional is a participant in the Alabama Impaired Professionals' Committee. He/she is providing this form to you to verify and document any/all medications that you are prescribing as part of your treatment.

Please assist us by completing the form below. Once completed, email a copy to the below email address, and maintain a copy for your records.

Should you have any questions, please contact our committee chair, John Bennett, DMD at (205) 331-0002. jcbennettdmd0414@gmail.com

PRESCRIPTION INFORMATION

Date of Prescription	Type of Medication	Quantity/Dosage Prescribed and # of Refills	Reason for Prescription

By signing below, I acknowledge that the above-named dental professional has informed me that he/she has a _____ problem.

Prescribing Practitioner Name: _____

Office Address: _____

Office Phone: _____

Prescriber's Signature

Date

Email form to: jcbennettdmd0414@gmail.com
