Canadian Rx Savings Program: Participant Intake Form

Employer: _____ **Date:** _____

1. Employee Information

Employee Name

Employee Address, City, State, Zip

Employee Email Address

Employee Date of Birth (MM/DD/YYYY)

Employee Primary Phone

Employee Work Phone

Eligible Medications:

2. Participant Information - *If the employee is not the person enrolling in the savings program*

Applicant Name

Applicant Address, City, State, Zip

Applicant Email Address

Applicant Date of Birth (MM/DD/YYYY)

Applicant Primary Phone

Applicant Work Phone

3. Medication Information

Please list medication allergies:

Please list current medications: