



PHARMACY ELECTION FORM

Dear Injured Worker:

Section 440.13(3)(j) of the Florida Statutes allows you to select a pharmacy or pharmacists to dispense and fill medications for your Workers' Compensation Claim. To ensure timely authorization of medications, please complete the information below:

Preferred pharmacy/pharmacist: _____

Pharmacy Location and/or contact: _____

This certifies that I, _____, select the above-named pharmacy/pharmacist to fill medications related to my Workers' Compensation Claim. This selection will remain in effect until contact is made with FSBIT to request a new election form

Signature

Date