[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

Date: [Insert Date]

To: [Pharmacy Name / Wholesale Distributor]
Address: [Pharmacy/Distributor Address]

Subject: Authorization for Emergency Drug Supply

To Whom It May Concern,

This letter serves as formal authorization for **[Name of Clinic]** to procure and maintain an emergency supply of medications as permitted under **[State/Local]** regulations for medical clinical use. These medications are intended for immediate administration to patients during medical emergencies occurring on-site at our facility.

The following individual(s) are authorized to order and receive these supplies on behalf of the clinic:

- **Authorized Personnel Name:** [Name]
- **Title:** [e.g., Lead Physician / Clinic Manager]
- **Professional License Number:** [License Number]

Requested Emergency Medications:

- [Medication Name 1] - [Strength/Quantity]
- [Medication Name 2] - [Strength/Quantity]
- [Medication Name 3] - [Strength/Quantity]

We certify that these drugs will be stored securely in a locked emergency kit or cabinet, monitored for expiration dates, and used solely for professional clinical purposes. All records of administration will be maintained as required by law.

Our facility's DEA Registration Number is: **[DEA Number]**
Our State Medical License Number is: **[State License Number]**

If you require further verification, please contact me directly at [Phone Number].

Sincerely,

[Signature]

[Printed Name]
[Title/Medical Director]
[Clinic Name]