

Date: [Insert Date]

To: [Pharmacy Name / Provider Name]

Address: [Pharmacy Address]

Subject: Authorization for Emergency Medication Restock

To whom it may concern,

This letter serves as formal authorization to restock the emergency medication supplies for [Facility Name / Department Name].

Due to [Reason for Restock: e.g., Expiration, Recent Usage, Periodic Audit], the following medications are required immediately:

- [Medication Name] - [Strength] - [Quantity]
- [Medication Name] - [Strength] - [Quantity]
- [Medication Name] - [Strength] - [Quantity]

Please ensure that all medications provided have the longest possible expiration dates. These medications are for emergency use only and will be stored in the designated [Emergency Kit / Medication Room / Crash Cart] located at [Specific Location].

The billing for this restock should be applied to [Account Number / Insurance Details].

If you have any questions regarding this request, please contact [Contact Person Name] at [Phone Number].

Sincerely,

[Signature]

[Printed Name]

[Title/Position]

[License Number, if applicable]

[Organization Name]