



*Prescription for Change*

# Certificate of Commendation Request Form

Your Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

Email: \_\_\_\_\_

Pharmacy Name	County

Unless otherwise specified by you, all certificates are signed by a CMA official and a Prescription for Change official. There is room for a third signature, often a community leader or policy maker from the specified County or City. Suggestions include:

- Tobacco Education Coalition President
- City or County Health Officer
- City or County Medical Society President

**(SPECIFY A THIRD SIGNATURE BELOW, PLEASE PRINT CLEARLY)**

Name and Degrees: \_\_\_\_\_

Complete Title: \_\_\_\_\_

**Please fax back to Prescription for Change  
415-512-0862**