Georgia Transplant Foundation

Enriching Lives Everyday

Selection of Pharmacy

As per my TFP application selection, I, _____, authorize the Georgia Transplant Foundation- Transplant Fundraising Program to use funds in my GTF account to pay the cost of my monthly medications directly to one of their partner pharmacies. I understand that it is my responsibility to monitor the statements of medications received and billed to my account and contact the pharmacy directly with any concerns.

I elect to receive my medications and have my account assessed by the following pharmacy.

(chose only one)

☐ **Community: A Walgreens Pharmacy**

☐ **Encompass Rx**

_____ _____

Print Name Date

_____ _____

Signature Transplant Date