**Section 2085.EXHIBIT E Research Order for Delta-9-Tetrahydrocannabinol**

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| STATE OF ILLINOIS | | | | | | | |  | | | | | | | | | | | | | | | | **ORDER SERIAL** | | | | | | | | | | |
| Blk PC Seal | | | | | | | |  | | | | | | | | | | | | | | | | **NUMBER** | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| *(Name of Hospital)* | | | | | | | | | | | | | | | | No. | | |  | | | | | | | |
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| DANGEROUS  DRUGS  COMMISSION  (312) 822-9860 | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| *(Address & ZIP Code)* | | | | | | | | | | | | | | | |  | | | | | | | | | | |
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|  | | | | | | | | *(Pharmacy DEA Number)* | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| RESEARCH ORDER FOR DELTA -9- TETRAHYDROCANNABINOL  *Valid for ONE bottle of NOT MORE THAN 25 capsules at above pharmacy ONLY. ORDER NOT REFILLABLE.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | |
| *PATIENT'S NAME:* | | | |  | | | | | | | | | | | | | | | | | | | | | *DATE:* | | | | |  | | | | |
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| *PATIENT'S ADDRESS:* | | | | | |  | | | | | | | | | | | | | | | | | | | *ZIP:* | | | |  | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | |
| *PERIOD COVERED BY THIS ORDER:* | | | | | | | | | | | | | |  | | | | | | | *198* | | | | *TO* | | |  | | | | | | *198* |
|  | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | |
| *AGENT (if applicable):* | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
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| *ORDER:* | DELTA-9-THC AT | | | | | | | |  | | | | | | | MGS | | | AT | | | |  | | | | | | | | | CAPSULES, | | |
|  | | | | | | | | | | *(Strength)* | | | | | | | | | | | | *(Quantity written in longhand)* | | | | | | | | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | |
| SIG: | | | | | | | | | | | | | | PATIENT IS TO RETURN UNUSED MEDICATION, | | | | | | | | | | | | | | | | | | | | |
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| I AFFIRM THAT INFORMED PATIENT CONSENT HAS BEEN OBTAINED. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
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| *(Patient's Signature)* | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | | | | | |  | |
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| M.D. ILL CONTROLLED SUBS NO: | | | | | | | | | | | | |  | | | | | | | M.D. FEDERAL DEA NO: | | | | | | | | | | | | |  | |
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| *DATE FILLED:* | | |  | | | | | | | | | *M.D. HOSPITAL AFFILIATION:* | | | | | | | | | | | | | | | |  | | | | | | |
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| *RECIPIENT'S*  *SIGNATURE:* | |  | | | | | | | | | | | | | | | *VERIFICATION*  *OF RECIPIENT:* | | | | | | | | |  | | | | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | |
| *REG PHARMACIST'S*  *SIGNATURE & NUMBER:* | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DDC FORM 299 (Series October 1980) Retain original in pharmacy; forward duplicate to DDC | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |