



Attain Med, Inc. New Customer Control Application

	5825 Glenridge Drive NE Building 4, Suite 106 Atlanta, GA 30328 Office: 770-288-2466, Fax: 888-288-2181 www.attainmed.com				
Attain Med, Inc. New Customer "Control" Account and Credit Application - (please print in block letters).					
General Information:		Sales Rep: _____ Date: _____			
Company Name: _____ DBA: _____					
Bill To Address: _____		State License No.: _____ Exp. Date: _____			
City: _____ State: _____ Zip Code: _____		DEA Registration: _____ Exp. Date: _____			
<input type="checkbox"/> "Ship To" Same as "Bill To"		Pharmacist-in-Charge: _____ License No.: _____ Exp. Date: _____			
Ship To Address: _____ Phone No.: _____ Fax: _____					
City: _____ State: _____ Zip Code: _____ Email: _____					
Type of Corporate Structure: Individual Partnership C-Corp S-Corp LLC # of Years in Business: _____ Tax ID: _____					
Principle: _____ Title: _____ SS #: _____ Phone No.: _____ % Ownership: _____					
Principle: _____ Title: _____ SS #: _____ Phone No.: _____ % Ownership: _____					
Principle: _____ Title: _____ SS #: _____ Phone No.: _____ % Ownership: _____					
A/P Contact: _____ Phone No.: _____ Email: _____					
Type of Business: Pharmacy Repackager Hospice Physician Hospital LTCF Chain Other: _____					
TRADE REFERENCES - Min. of two (2) Req'd					
Name: _____ Phone No.: _____		Name: _____ Phone No.: _____			
Contact: _____ Acct No.: _____		Contact: _____ Acct No.: _____			
Bank Reference: Name of Bank: _____ Acct No.: _____ Routing No.: _____ Years w/ Bank: _____					
Contact: _____ Phone No.: _____		Total RX P/Month: _____ Est. Annual Sales: _____			
Has the firm or any of its principles ever been bankrupt? Yes No		If Yes, explain (use add'l paper if nSSRE): _____			
Please provide a list of all "suppliers" you currently use and intend to continue to use, as well as, % of "controls" and "non-controls" you purchase from each:					
Name of Current Suppliers:	% non-controls	% controls	Name of Current Suppliers:	% non-controls	% controls
Payments: Are you seeking payment terms? Yes No			** Note: Terms are given based on several factors and are approved on a case by case basis		
Options: 1st thru 15th, due on 25th, 16th thru 30th, due on 10th		Net 5	Net 15	Preferred Payment Method: Bank Wire	
Preferred Payment Method - Cont'd: Cash on Delivery			ACH Draft; to be paid on invoice due date		Mail Check
Credit Card on File (2% Fee)					
Any misrepresentation in this application will be considered evidence of fraud, since this info is the basis for the extending of credit. As an inducement to grant credit, the undersigned warrants that the information submitted is true and correct. You are authorized to investigate the credit references and principles listed.					
In consideration for the extension of credit, said business promises to pay for all purchases within the terms agreed _____ and agrees to pay a service charge per month of 1.5% per month (18% annual percentage rate) on all past due balances. In the event any third parties are employed to collect any outstanding monies owed by said business the undersigned agrees to pay reasonable collection costs, including attorney fees, whether or not litigation has commenced, and all costs of litigation incurred. The undersigned represents that he/she has the authority to execute this credit agreement on behalf of the business identified.					
Company Name: _____			DBA: _____		
Print Name: _____			Title: _____		
Signature: _____			Date: _____		
Print Name: _____			Title: _____		
Signature: _____			Date: _____		
Directions: Please fax completed application, along with supporting documents to 888.288.2181, or email to "applications@attainmed.com".			a) Completed Application		
			b) Copy of State License, Personnel License/Certs (i.e. Pharmacist(s), Tech(s), etc.)		

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Attain Med, Inc. Control Customer Questionnaire - (please print in block letters) .

Personnel - Section I	Pharmacist(s) Attach add'l sheet if nSSRE :	License No.:	Exp. Date:

Customer Volume & Supplier Questionnaire - Section I

1) Which type of "controls" is the facility authorized to sell (check all that apply):		2	2N	3	3N	4	5
2) Does your facility provide internet product fulfillment?	Yes	No	2a) If "Yes", are you VIPPS Accredited?		Yes	No	
3) Do any of the owners operate/own any other pharmacies?	Yes	No	3a) If "Yes", please list details for each pharmacy:				

Name: _____		Name: _____	
Address: _____		Address: _____	
City: _____	State: _____	Zip: _____	City: _____
Pharmacist-in-Charge: _____		Pharmacist-in-Charge: _____	

4) Please provide the "Practice Information" (i.e. Practice Name, Address, DEA No., and Contact No.) for your "Top 3" prescribing physicians over the last "six" (6) months (attach additional sheet, if necessary):

Practice Name:	Practice Address:	Contact Name & No.:	DEA No.:

5) Average # of scripts filled "p/Day" and/or "p/Month" (Please specify - p/Day or p/Mo.): _____ per/Day _____ per/Month

6) Has the owner or any employee practicing at the facility ever had a DEA registration suspended and/or revoked? Yes No
 If "Yes", provide details: _____

7) Has the owner or any employee practicing at the facility ever been sanctioned by a regulatory agency? Yes No
 If "Yes", provide details: _____

8) Has the owner or any employee practicing at the facility ever had its state license suspended or revoked? Yes No
 If "Yes", provide details: _____

9) Attach and Date Pictures of Customer Facility with "New Account Application" (See next row for specifics): a) front of building with signage, b) hours of operation on door, c) waiting area, d) dispensary, e) patient consultation area, f) area behind pharmacy counter, g) C-II vault, and h) rear door

10) Does the Pharmacy offer a full assortment of sundries to its customers? Yes No

11) Does the Pharmacy have any other license(s) and/or registration(s) (i.e. dist., repacker, exporting, etc.)? Yes No If "yes", provide copies: _____

12) Does the pharmacy fill scripts for Pain Mgmt or other specialty practitioners (weight loss, oncology, etc.)? Yes No If "yes", provide details: _____

13) Does the Pharmacy conduct an extensive "due diligence" (Know Your CSR) assay of physicians it fills Rx's for? Yes No If "yes", provide details: _____

14) Does the Pharmacy supply, order for, or sell to any practitioners or other pharmacies? Yes No If "yes", provide details: _____

15) Is the Pharmacy licensed as a mail order pharmacy? Yes No

16) Does the Pharmacy fill prescriptions for out of state customers? Yes No

17) Does your state mandate you to use a Prescription Drug Monitoring Program (PDMP) when dispensing "controlled substances"? Yes No
 If "Yes", which (PDMP) software/website do you use? _____

18) Do you require to have patients to have "state identification" when purchasing prescription products? Yes No

19) Does the Pharmacy have a website? Yes No If "Yes", provide URL: _____

20a) What percentage of your sales are paid with cash? _____ % 20b) What percentage of your business is from "walk-in" customers? _____ %

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QUESTIONS [continued]

Section 1306.04 Purpose of issue of prescription

a) In-order for a controlled substance (CS) prescription to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of CS is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of "section 309 of the Act (21 U.S.C. 829)" and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to CS

(b) Prescriptions may not be issued in-order for an individual practitioner to obtain CS for personal use, but can only be issued for the specific purpose of dispensing to patients with medical necessities.

(c) A prescription may not be issued for "detoxification" or "maintenance", unless the prescription is for a Schedule III, IV, or V "narcotic" drug approved by the FDA specifically for use in maintenance or detoxification treatment and the practitioner is in compliance with requirements in §1301.28 of this chapter.

Please "initial" that you **have read and understand Section 1306.04**

Affidavit of Physical Pharmacy & Diversion Control Program

The undersigned hereby swears, attests and covenants as follows: I am the duly licensed professional ("**Provider**") and is currently in good standing, with no past due accounts, all of the operations and procedures of Provider comply with all applicable provisions of the Code of Federal Regulations (CFR's), and any applicable State Laws/Regulations as they pertain to the purchasing, storage, and handling of controlled substances. The professional license submitted to Attain Med is a valid license for where Provider practices and has authorized this location listed below to submit purchase orders for prescription medications that will remain under my direct supervision. This licensure and registration will remain in effect until written notice is provided to Attain Med as to the instruction of Provider to remove this registration and my direct supervision of this location. The undersigned agrees to notify Attain Med immediately upon any changes in the status of Provider's licensure. The undersigned hereby certifies that Provider does not knowingly sell or divert control substances to individuals and/or to other marketers, including, without limitation, internet pharmacies that are not certified by the National Association of Board of Pharmacy (NABP) as a Verified Internet Pharmacy Practice Site (VIPPS). The undersigned does hereby state that this information and any information in the account file of Provider is accurate and true.

Signature & Title: _____ Print Name: _____ Date: _____

TERMS AND CONDITIONS: This application is for direct ordering of pharmaceutical products and is subject to acceptance of Attain Med. The terms and conditions, including pricing, related to sale of products are fully set forth in the account price list and are subject to change at any time. It is the responsibility of the account holder or its representative to report any discrepancies of any matter. If this application is accepted, the newly approved account holder and its representatives agree to be bound by the terms and conditions prevailing at the time of each order. Should there be any conflicts between the terms and conditions of the prevailing pricing list, the former T&Cs shall prevail. **Attain Med will adhere to a strict compliance regiment that meets those standards set forth by the regulatory organizations which are responsible for ensuring the highest guidelines are met with regards to "Suspicious Order Monitoring System" (SOMS) and we will develop limits based on actual "drug utilization report" (DUR) provided by customer at time of initial application.** The DUR must show items ordered based on quantities specified within a customer's previous three (3) month drug utilization (DUR) report provided with this application. At any point Attain Med retains the right to ask specific questions pertaining to customers reaching and/or exceeding limits of ordering Controlled Substances. Attain Med uses the electronic Controlled Substance Ordering System (CSOS) whenever C-II's are ordered and Customer will need to have an account setup via the DEA within six (6) weeks of account being approved.

Attain Med reserves the right to hold any order out of compliance based on this application. Background checks may be performed on all persons listed on application. Attain Med reserves the right to conduct an independent unannounced on-site inspection prior to the final approval of any customer planning to purchase "schedule II" drugs prior to final account approval. Alternately, Attain Med (DEA) Compliance personnel may contact the customer and schedule a teleconference for additional understanding and due diligence. This application questionnaire is part of our effort to comply with DEA Regulations, Policies, Procedures, Guidelines and Emerging Interpretations of a wholesaler's responsibilities concerning "Knowing Its Customers" and Order Fulfillment and Monitoring. Attain Med views this activity as mutually beneficial to the customer as well as itself, and also as a support function to assist its customer to achieve the highest level of compliance with the Controlled Substances Act and Code of Federal Regulations Part 1300 to End. Customer must contact Attain Med before conducting prescription internet fulfillment, and/or make any significant changes to business process, as well as, notify Attain Med of any changes to the Suppliers being used after account has been open and approved by management.

Signature & Title: _____ Print Name: _____ Date: _____

Application Instructions: Please ensure that every question is addressed and if it does not apply, please place an "N/A" in the space provided. **DO NOT LEAVE ANY BLANK QUESTIONS!** You may scan and email, entire "application" along with "supporting documents" to "applications@attainmed.com", and/or fax to 888-288-2181. Please make sure to sign where requested, as well as, Initial each page. This will assist in expediting the approval process. Thanks in advance!

I declare under the penalty of perjury that the foregoing information provided is accurate and true.

Directions: Please fax completed application, along with supporting documentation to 888.288.2181, or email completed package to "applications@attainmed.com".

a) Copy of all Federal, State, & Local Licenses, most recent On-Site Inspections and requested pictures (8 in total).

b) Copy of State License, Personnel License/Certs (i.e. Pharmacist(s), Tech(s), etc.)

c) Copy of DEA & State "Control" License (If App). Attain Med reserves the right to request a summarized 90-day "Drug Utilization Report" (DUR), which must be generated from pharmacy system. DUR must have the following info: Drug Name, Dosage, NDC, Schedule, Total Rx Filled & Qty Dispensed, Date Filled, CSR ID, & Address {w/o Violating HIPPA Laws}).

Signature & Title: _____ Print Name: _____ Date: _____