(877) 476-4761
dsupon@rxoneshop.com
dougs@rxoneshop.com

APPLICATION FOR CREDIT

Legal Name of Business: Type name here

Bill to Address: _____ **City**_____ **State**___ **ZIP**_____

Ship to Address_____ **City**_____ **State**___ **ZIP**_____

Phone:_____ **Fax:**_____ **Email:**_____

DEA#_____ **Exp Date**_____ **State License #**_____ **Exp Date**_____

Accts Payable Manager_____ **Buyer's Name**_____

Ownership: ☐ **Sole Proprietor** ☐ **Partnership** ☐ **Corporation** ☐ **LLC** **Years in Business**_____

Owners or Officers:

Name_____ **Phone Number:**_____

Primary Wholesaler, Bank Info, D&B Number and Trade References are required information

Primary Wholesaler: _____ **City**_____ **State**_____

Account #:_____ **Phone #**_____

Bank Name: _____ **Account #:**_____ **Phone #**_____

Fax #_____ **Contact:**_____

D&B #: _____

Trade References:

Name: _____ **Acct#:**_____ **Phone #**_____

Name: _____ **Acct#:**_____ **Phone #**_____

Authorized Signature*:_____ **Printed Name:**_____

Title: _____ **Date:**_____

AUTHORIZATION TO INVESTIGATE CREDIT: The above information is for the purpose of obtaining credit and is warranted to be true. I/We hereby authorize the firm to whom this application is made to investigate the references listed pertaining to my/our credit and financial responsibility.

*By signing Applicant acknowledges that it is requesting RxOneShop.com to provide their request for credit to each Supplier RxOneShop.com represents and Applicant agrees to the Supplier(s) Terms and Conditions including those on Page 2 of this application. RxOneShop.com will at the request of the Applicant provide a list of Suppliers to whom the credit application is being provided.

Fax Application For Credit with DEA Certificate and State License to (877) 578-0545

This credit application form is provided as a convenience to Customers, eliminating the need to complete individual credit applications from multiple Suppliers. RxOneShop.com does not approve or extend credit.

New Customers: Credit will be extended at the sole discretion of each Supplier. By signing Customer represents that all information contained herein is correct and complete and that the Supplier(s) may rely on such information in deciding to extend or discontinue credit. Each individual Supplier retains the right to extend or not extend credit and the amount of said credit to be extended.

Standard Payment Terms: Net 30 Days subject to credit approval

Payment Method Accepted: Mailed check or electronic payment made payable to the Supplier that invoiced the Customer

Credit Limits: Customers are normally given a credit line sufficient to accommodate their order requirements. Requests for credit limit increase may require additional financial information and/or altered payment terms.

Finance Charge: Accounts 30 days or more past due will incur a finance charge of 1.5% per month (18% per annum).

DEA & State License: Customer acknowledges that current DEA Certificate and State License have been provided with this Application for Credit. Failure to provide DEA Certificate and State License with this Application for Credit may delay credit approval.

Permissions: Customer grants permission to RxOneShop.com and Supplier(s) to send advertising and promotional materials to the email(s) and fax number(s) provided.

Customer requests that RxOneShop.com register Customer to access www.rxoneshop.com for the purpose of placing orders.

Customer acknowledges and agrees that all pricing and inventory information provided by Supplier(s) constitutes confidential and proprietary information that Customer shall keep in the strictest confidence. Customer will not share such information with any third parties including without limitation other wholesalers, manufacturers or retailers.

Fax Application For Credit with DEA Certificate and State License to (877) 578-0545

Pharmacy Questionnaire

This questionnaire is to be completed by the Owner/Manager or Authorized Pharmacist in Charge
PLEASE COMPLETE ENTIRE FORM, SIGN AND DATE

Pharmacy Name: Type pharmacy name here

Pharmacy's dba (doing business as), if any _____
Has the pharmacy ever operated under a different name? Yes ☐ No ☐
If yes, provide the Name: _____

Pharmacy Address: _____

City _____ State _____ Zip _____

Pharmacy Phone Number: _____ Fax Number: _____

Pharmacy Email Address: _____

Name of Store Owner(s) _____

Name of pharmacist – in – charge _____

Name of person responsible for payment of invoices: _____

Contact Name _____(first) _____(last) Title:_____

Contact Email address:_____

Does the pharmacy have a web site? Yes ☐ No ☐
if yes, provide web address(es): _____

Is this pharmacy affiliated with any other pharmacy or internet website that allows orders to be placed over the internet? Yes ☐ No ☐ if yes, describe. _____

_____

Number of years owner has operated pharmacy: ___ Number of years at this address.___

Is the Owner a licensed pharmacist? Yes ☐ No ☐

Pharmacy DEA registration #: _____Expire Date _____(attach copy)

Has the Pharmacy ever had a DEA registration or license suspended or revoked?
Yes ☐ No ☐ If so, give details (when, why, etc.)

State Board of Pharmacy Registration # _____ (attach copy)

Does the pharmacy have any other licensure/registration (pharmacy, wholesale, repackager, etc.)?
Yes ☐ No ☐ if yes, please provide copies.

Date of last Regulatory Inspection _____ Inspecting Agency _____
(Please include a copy of your latest inspection report)

Has this pharmacy ever had any disciplinary actions? Yes ☐ No ☐
If Yes, Please explain the disciplinary action: _____

_____

Has any pharmacy employee ever had any disciplinary actions? Yes ☐ No ☐
If Yes, Please explain the disciplinary action: _____

_____

Please feel free to attach additional pages to include other comments or information you feel we should know about your pharmacy.

The undersigned agrees that the responsibility of payment is acknowledged and invoices are due and payable as designated by the Creditor. Unpaid invoices beyond the terms will be cause for cessation of future shipments. All amounts payable will be paid within the terms given, and if not paid on or before the due date, are then delinquent. Creditor may terminate credit availability within its sole discretion. It is understood that creditor may impose and charge a finance charge or delinquency charge which is the lower of one and one-half percent (1.5%) per month or the highest rate allowed by law on any amount which becomes past due and delinquent. Additionally the undersigned shall be responsible for all collection costs and attorney's fees in connection with any delinquent amount. In addition, there will be a twenty-five dollar ($25.00) fee charged on any check or other payment method made that is returned unpaid by the bank or any other financial institution.

I, _____("Customer") as the ☐ owner ☐ representative, have completed this form to the best of my knowledge and ability. The customer agrees that it will abide by all applicable laws, rules, regulations, ordinances and guidance of the federal Drug Enforcement Administration (DEA), the United States Food and Drug Administration (FDA), the states into which it dispenses controlled substances and the states in which it is licensed. Further, Customer agrees that it will not dispense controlled substances if it suspects that a prescription is not issued for a legitimate medical purpose or in the normal course of professional practice.

In addition, Customer agrees that it understands that Quest Pharmaceuticals is required by DEA regulations to report to the local DEA Diversion field office any instances of suspicious orders of controlled substances pursuant to DEA guidelines. To this end, Customer agrees that it will be alert for red flags of suspicious orders/prescription fill requests, such as: a) numerous controlled substance prescriptions written for the same drugs, in the same quantities for the same time period by the same or different prescribers or group of prescribers for the same patient; b) numerous controlled substance prescriptions written for the same person or several persons by the same prescribes or group of prescribers; c) numerous prescriptions written for the same patient by prescribers located in different states than the patient; and/or d) any other red flags that would indicate that controlled substance prescriptions are not for legitimate medical purposes.

Customer agrees that if any potential red flags are identified, it is advisable to contact the prescriber(s) to validate the legitimacy of the prescription and/or to discontinue filling prescriptions from the prescriber, group of prescribers, and/or customer in question. In addition, the pharmacist should contact the State Board of Pharmacy or local DEA Diversion Field Office.

Further, Customer will provide to Quest Pharmaceuticals any information regarding its distribution of controlled substances which Quest Pharmaceuticals may need to evaluate compliance with DEA regulations. Quest Pharmaceuticals reserves the right in all cases to limit or eliminate any sales of controlled substances to customers in any situation which it determines in its sole discretion pose issues or questions of proper usage and/or adequate legal compliance by the Customer. Quest Pharmaceuticals required a minimum of ninety days of purchasing history prior to shipment of any CII products.

Customer acknowledges that Quest Pharmaceuticals may provide a copy of this agreement to the DEA, other federal regulatory agencies, state regulatory agencies, or state licensing boards when determined to be appropriate.

Customer agrees that failure to comply with this Agreement may result in the termination of the relationship between Quest Pharmaceuticals and Customer, in whole or in part, notwithstanding any other agreements to the contrary.

_____ _____

Full Name (Print) Title:

_____ _____

Signature: Date:

HealthSource
The SmarterRx Source

CUSTOMER AGREEMENT AND CREDIT APPLICATION

P: 410-653-1113 F:410-415-7004
www.HealthSourceDistributors.com

ACCOUNT INFORMATION

Legal Business Name:	Trade Name:	Date:	
Street Address:	City:	State:	Zip Code:
Telephone No:	Fax:	Cell No.:	
E-Mail:			
Type of Business (e.g. Corp, Partnership, LLC, Proprietorship):		State of Organization:	
List additional Businesses owned by principal(s):			
State Board of Pharmacy License No.:	Expiration Date:	NABP No.: *(attach copies)*	
DEA License No.:	Expiration Date:	Re-Sale No.:	

Principals Names:	Ownership %:	Home Address:	Cellular No.:	Social Security No.:

BUSINESS INFORMATION

How long in business?	How long at this location?
Own or Rent Business the location?	If rent, name, address and telephone no. of landlord:

Has Applicant or any principal(s) filed for bankruptcy either personally or on behalf of any business in past ten (10) years? ☐ Yes ☐ No

Is Applicant (or Principal(s) thereof) currently a defendant in any legal proceeding? ☐ Yes ☐ No	Is Applicant or any principal(s) currently a defendant in any legal proceeding? ☐ Yes ☐ No

Has Applicant or any principal(s) ever been charged/convicted with a felony or misdemeanor? ☐ Yes ☐ No

Are there investigations/audits (current or past) concerning Applicant or any principal(s) of Applicant by a gov't office, PBM or ins. carrier? ☐ Yes ☐ No

TRADE REFERENCES

Company Name ,Telephone Number, and Contact Name:

Primary vendor:
Secondary vendor:

BANK REFERENCE

Name:	Account No.:
Contact Person:	Telephone No.:
Address:	

The undersigned agrees that the following terms and conditions are applicable to all purchases made by Applicant and shall constitute a contract between the Applicant and HealthSource Distributors, LLC

1. Applicant warrants that all information set forth in this Application is a true representation for the purpose of obtaining credit from HealthSource. Any willful misrepresentation shall constitute a default by Applicant in its agreement with HealthSource Distributors, LLC ("HealthSource"), and shall result in disqualification of Applicant as a customer.
2. Payments terms are set forth on invoices. Payments not received on or before the date(s) set forth on the invoices shall be deemed late. Should the due date fall on a holiday or weekend, then payment is due at HealthSource on the preceding business day.
3. The signatories hereto hereby authorize HealthSource to conduct such investigations as it may deem necessary to verify their creditworthiness and agree to release all persons, companies, or corporations using or supplying such information, including HealthSource, from any claims and/or losses that may result therefrom.
4. HealthSource may in its sole discretion, at any time, without prior notice, discontinue service, change Applicant's credit terms, cost of goods, discount, services or programs and require payment in cash before shipment of any and all merchandise. Applicant waives any and all claims against HealthSource for said conduct.
5. In case of default by Applicant, Applicant and Guarantor (see below) agree to reimburse all of HealthSource's reasonable costs of collection, including but not limited to, attorneys' fees.
6. Applicant agrees to immediately notify HealthSource, in writing, of any of the following events affecting Applicant or its owners/operators: bankruptcy (business or personal), investigation (Medicaid or otherwise), disciplinary hearing, suspension, licensing issue, PFP/provider audit, legal proceedings, judgments, liens or any change in financial condition.
7. A late fee assessment of 1.5% per month or the highest amount allowed by law, if lower, may be charged to the outstanding balance if payment in full is not received timely.
8. Applicant understands, accepts and agrees that in the event a payment fails to clear the collection process, Applicant shall be subject to a $100.00 service charge per rejection.
9. HealthSource's acceptance of any payment for less than the full amount of the indebtedness owed shall not constitute a waiver of HealthSource's right to collect the balance (notwithstanding any endorsement on any check or other instrument) and shall not be deemed an accord and satisfaction.
10. Applicant agrees to provide HealthSource with advance written notice of any change in ownership, management and/or control of Applicant. In any such event, all open invoices shall immediately become due and payable. Applicant agrees not to transfer/assign any open balance without HealthSource's written consent.
11. Applicant agrees to abide by HealthSource's Return Goods Policy (as may be amended – see website for details). Unauthorized returns will be destroyed and no credit will be issued.
12. Applicant agrees to indemnify and hold HealthSource and its officers, shareholders and employees harmless from and against any and all claims, liabilities, losses, costs and expenses (including attorneys' fees), arising directly or indirectly out of: (a) the fraud, intentional misconduct, omission or negligence of Applicant; and (b) the marketing, storage, distribution, sale or use of products sold to Applicant by HealthSource, including claims for personal injury, death and/or property damage.
13. No failure or delay to exercise any power, right or privilege and no course of dealing shall operate as a waiver of any power, right or privilege hereunder.
14. **PERSONAL GUARANTEE –** The undersigned personally guarantees prompt and full performance of all obligations due and owing by Applicant to HealthSource under this and/or any other agreement with HealthSource. In the event of default, HealthSource and/or any holder hereof is authorized to proceed against the undersigned guarantor, without first having to proceed against Applicant, for the full amount due, including late payment charges, interest, costs and attorneys' fees. The undersigned waives presentment, demand, protest, notice of protest, notice of dishonor and any and all other notices or demands of whatever character to which the undersigned might otherwise be entitled. The undersigned further consents to any extension granted by HealthSource and waives notice thereof. If more than one guarantor, the obligation of each Guarantor shall be joint and several. Termination of this Guarantee must be in writing, signed by HealthSource and undersigned, and in such event, shall only apply as to future obligations.
15. **SECURITY AGREEMENT** - To secure Applicant's existing and future liabilities to HealthSource, Applicant grants HealthSource a security interest upon all personal property of Applicant, wherever located, now owned or hereafter acquired, including but not limited to, accounts, insurance proceeds, inventory, prescription records, equipment, fixtures, contract rights, customer lists, cash on hand/deposit, telephone numbers and all other tangibles and general intangibles, including replacements and proceeds of the foregoing, now owned or that may hereafter arise (collectively, the "Collateral"). Applicant authorizes HealthSource to file a UCC-1, along with amendments and extensions thereto. Applicant will cooperate with HealthSource in obtaining control of the Collateral. Upon default by Applicant, HealthSource shall have the right to enforce its rights against the Collateral. HealthSource may pursue any remedy available at law and/or equity, including those available under the Uniform Commercial Code.
16. The undersigned, having the authority to bind Applicant, acknowledges having read and reviewed this document, and further warrants, covenants and agrees to pay and perform all of the obligations secured by this Credit Application according to the stated terms.

Guarantor: *(Print)*	Guarantor: *(Sign)*	Applicant: *(Print name and Title)*	Signature: