Office: 305-887-1236
Fax: 305-907-5307
8105 West 31st AVE
Hialeah FL, 33018

Wholesale Pharmaceuticals and Supplies Application

Name of Applicant or institution:
____

Please use the following Checkpoints to ensure completion of application:

- Account Application
- Pick method of payment form (Credit Card, ACH or Terms via invoice)
- Latest inspection report of the practice
- Resale Certificate if applicable
- Attach EIN#
- Hours of operation

Please provide pictures or copies of:

- Front of the Building including signage
- Copy of State license
- Full Name of all physicians, each one should have attached a copy of State License

Email: Orders@MedSavOn.com

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Account Application

At the completion of this form please Fax or email back to us to ensure a quick response by our application department. They will contact you within 48 Hours of receiving the application.

Shipping Information

Company Name:
Contact Name:
Address:
City:
State:
Zip:
Phone:
Alt Phone:
Fax:
Email:
Website:

◯ Please check if the same as Shipping

Billing Information

Company Name:
Contact Name:
Address:
City:
State:
Zip:
Phone:
Alt Phone:
Fax:
Email:

Dispensary Physician(s)

Physician of Record:	Phone:	Email:
State License No.:	Exp Date:	State Dispensing License No.:
AP Manager:	Phone:	Email:
Purchasing Manager	Phone:	Email:

Sav+On Medical Supplies Inc.

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Licensing

(Attach a copy of State license of all physicians working under the practice)

Name:	Location:
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Please Circle the days of Operation

Sunday Monday Tuesday Wednesday Thursday Friday Saturday
Hours of Operation: ____
Are all State, Federal Licenses current and are they issued for the registered address at which the practice is practicing? YES__________ NO__________

Warranties

I,____represent and warrant:

- That I shall comply with all applicable laws and regulations in connection with ordering, possession and dispensing of pharmaceuticals products acquired from Sav-On.
- That I am responsible for the inventory of pharmaceutical products ordered and acquired.
- That my license(s) are not restricted in any manner that would prevent me from ordering, possessing, and dispensing the pharmaceutical products ordered from Sav-On during the term of this agreement.
- That if during the term of this agreement, facts and circumstances change to the extent that any of the aforementioned representations and warranties are no longer true, I shall notify Sav-On in a timely manner prior to or immediately upon the affect change.
- That I hold all licenses in good standing which are required to allow me to possess and dispense pharmaceutical products of the type I will order under this agreement. Included with this paperwork are copies of the following licensure:

______State Practitioner License
______State Dispensing License (If applicable)

Primary Practitioner signature:____________________________________DATE:______________________

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Survey

Instructions: Please fill every question the fullest of your knowledge. If it does not apply, please place an "N/A" in the space provided. Any blank questions will delay the approval process.

1. Company Name:
2. Company Physician-In-Charge (PIC):
3. Company Contact:
If not PIC, title of contact person:
4. Company Owner:
5. Name of Facility:
6. Date Opened:___/____/____Number of Employees:______ 7. Number of Locations:_______
8. What is the facility's primary customer base?
☐ Community
☐ Geriatric
☐ Pediatric
☐ Worker's Comp
☐ Pain Management
☐ Other_____________
9. Does your facility does any Institutional/Closed Door business? _____Yes _____No
If Yes*, how many beds? _______

Supplier Info

10. Average of orders/scripts filled per day or month? ________
11. Is the facility located within a medical center of professional building? ____Yes _____No
____Medical ____Clinic ____Hospital ____Medical Center ____Medical Building
12. Please list the name of other suppliers use at your practice.
Providing (Supplies or Pharmaceuticals)
____ ____
NOTE: "All medication prescribed must follow all State and Federal laws and regulations. All prescribed medications must be deemed for use for a legitimate medical purpose via doctor-patient relationship"

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I, declare, under penalty of perjury, that the foregoing is true and correct.
By (License Holder): ______________________________________Date: ___________________
Full Name and Title (License Holder):____

I declare under penalty of perjury that the foregoing is true and correct.
Date executed: ____

Signature (must be signed by Owner, Director or Physician):

Owner/Officer Signature: __________________________________Date: ___________________
Print Name: ____ Title: ___________________

Physician Signature: ______________________________________Date: ___________________
Print Name: ____Title: ___________________

Terms and Conditions

The information on this application are true to best of the knowledge, to stablish an account with Sav-On. Sav-On is free to do its due-diligence in assuring information on this application is correct. By signing you have agree to the terms of payment for supplies/pharmaceuticals invoiced by Sav-On. Authorizing to bill an interest computed at the rate of 1% per month or the maximum amount allowed by law on any past due amount owing on the account. In the case is necessary to incur a collection company, any amount due from extra charges of collection will be added to the bill. The undersigned is signing this agreement in two capacities, both for the company applicant and as an individual. I, the undersigned, in my individual personal capacity, by this agreement do expressly personally, unconditionally, jointly, severally, irrevocably and continually personally guarantee to pay the indebtedness of the company applicant to Sav-On for all goods and merchandise purchased by the company applicant. In so doing, I, the undersigned, expressly warrant and represent that I have read and understand this entire agreement and it is my intention by signing this agreement to personally guaranty and assume joint and several responsibility to Sav-On along with the company applicant.

I understand that Sav-On does not accept returns of medication._________
(Initials)

I have read and accepted the terms of the Privacy Policy and Disclaimer by Sav-On. These policies and disclaimers may change from time to time and it is my responsibility to remain up to date with these changes._________
(Initials)

I certify under penalty of perjury that the forgoing information is true and correct. I also agree to contact Sav-On if there is any changes in the regulatory status o this Business such as a change in licensure or ownership.

Authorized Signature: ___________________________________
Print Name: ____Title: ___________________________

Email: Orders@MedSavOn.com