GEN-SOURCE RX
Profitable partnerships in generic pharmaceuticals

620 Gotham Parkway
Carlstadt, New Jersey 07072
Tel: 877-443-6768 Fax: 201-804-8885

ACCOUNT & CREDIT APPLICATION

Account No.: _____ Sales Rep No.: _____ Date: ___/___/_____

Customer's Legal Name: _____
DBA/Trade Name: _____ Website: _____
Owner's Name: _____ Email: _____
Billing Contact: _____ Phone: _____ Fax: _____
Billing Address: _____
City: _____ State:_____ Zip: _____
Name of pharmacist in charge: _____ Pharmacist's License No.:_____
Send billing statements via: (check all that apply):

- ❑ Email Email address (if different from above): _____
- ❑ Fax Fax number (if different from above): _____
- ❑ Regular Mail

Pharmacy Days and Hours of Operation: _____
Shipping Contact: _____ Phone:_____ Fax: _____
Shipping Address (if different from billing): _____
City: _____ State:_____ Zip: _____

Credit Information

Primary Wholesaler: _____ Account No.: _____
Address: _____
City: _____ State:_____ Zip: _____ Phone:_____ Fax: _____
Secondary Supplier: _____ Account No.:_____
Address: _____
City: _____ State:_____ Zip: _____ Phone:_____ Fax: _____
Other Supplier: _____ Account No.:_____
Address: _____
City: _____ State:_____ Zip: _____ Phone:_____ Fax: _____

Bank Reference

Bank Name: _____ Account No.: _____
Address: _____
City: _____ State:_____ Zip: _____ Phone:_____ Fax: _____

We certify that the above information is true and correct, and we agree to pay this account in accordance with your credit terms. We authorize you to verify this information, now or in the future, and/or obtain a dditional information by securing data from a credit reporting agency. We understand that all past due balances will be subject to 1 1/2% per month service charge. For good and valuable consideration, the company, as represented by the undersigned, agrees to be liable for all indebtedness incurred by the above.

_____ _____ _____
Authorized Signature Title Date

Print Name: _____ Phone: _____

Business Information

1. When did the pharmacy begin operating (approximate date)?:_____

2. Does the owner operate/own any other pharmacies? ❑ Yes ❑ No
   If yes, please provide the following information for each location. (Attach a separate page if necessary.):
   A. Pharmacy Legal Name:_____ Trade Name: _____
      Address: _____
      City:_____ State:_____ Zip: _____ DEA License No.: _____
   B. Pharmacy Legal Name:_____ Trade Name: _____
      Address: _____
      City:_____ State:_____ Zip: _____ DEA License No.: _____

3. Is the pharmacy a closed door pharmacy? ❑ Yes ❑ No

4. How does the pharmacy receive business? (Check all that apply)
   ❑ Walk-in ❑ Phone ❑ Fax ❑ Internet ❑ Mail Order

5. Is your pharmacy associated or affiliated with any other pharmacies or internet websites? ❑ Yes ❑ No
   If yes, please explain: _____

6. What percentage of prescriptions are paid by each of the following?:
   Insurance _____% Cash / Credit Card _____% Other* _____%
   *Other, please explain:_____

7. Which best describes your pharmacy (check one)?:
   ❑ Retail Pharmacy ❑ Retail Chain Pharmacy ❑ Hospital Pharmacy
   ❑ Other (Clinics, Nursing Homes, LTC, etc.) Please Explain: _____

8. Does your pharmacy service pain management clinics, nursing homes, or LTC facilities? ❑ Yes ❑ No
   If yes, what are the percentages of prescriptions filled for each type of facility?:
   Pain Management Clinic: _____% Nursing Home: _____% LTC:_____%
   Please provide the following information pertaining to any Pain Management Clinics with which you are associated (attach additional pages if necessary):
   Name: _____
   Address: _____
   City: _____ State: _____ Zip Code:_____

9. How many prescriptions does your pharmacy fill daily on average? _____

10. What percentage of your prescriptions are Controlled Substances on average? _____%

11. What are the average total dosage units your pharmacy dispenses per month for each of the following?:
    Hydrocodone units: _____ Alprazolam units: _____ Oxycodone units: _____

12. Does your pharmacy fill prescriptions for: out-of-state patients? ❑ Yes ❑ No
    out-of-state prescribers? ❑ Yes ❑ No

13. Has your pharmacy ever had a DEA Registration suspended or revoked? ❑ Yes ❑ No

14. Has your pharmacy's owner ever had a DEA Registration suspended, revoked or disciplined? ❑ Yes ❑ No

15. Has your pharmacy ever had its state license suspended, revoked or disciplined? ❑ Yes ❑ No

16. Has the Pharmacist in Charge or the pharmacist/owner ever had their state license(s) suspended, revoked or disciplined? ❑ Yes ❑ No

17. Please complete the attached form, listing everyone with a Power of Attorney to sign DEA 222 Form even if you do not plan to purchase C2's from Gen-SourceRx.

18. Please email photos of your store to your Sales Representative as follows:
    A. Photo of the outside of the pharmacy taken from a distance, showing the outside of the business along with the adjoining one or more businesses if any.
    B. Close-up photo of the outside of the pharmacy showing address, suite, and hours/days of operation.
    C. Photo of the inside of the pharmacy showing the shelves and OTC products for sale.
    D. Photo of the pharmacy counter, drop off, and pick up area.
    E. Photo showing the operation behind the counter where prescriptions are filled and med's are stored.

19. Please provide a three (3) month Drug Prescription Report for all pharmaceuticals your pharmacy purchases. The report should show (a) drug name, (b) NDC, (c) number of new prescriptions, (d) number of refills, (e) manufacturer, and (f) quantity dispensed. The report should indicate the covered time period. Preferably, the last page should have totals, especially for the number of prescriptions, and the total number of pages should be shown.

I hereby certify that the information I have provided on this application is true and accurate:

Signature: _____ Date: _____

Print Name: _____ Title: _____

Email: _____ Phone: _____

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DEA FORM 222 SIGNATURE CARD

Account No.: _____

Customer Name.: _____

Please complete all required information for employees with Power of Attorney to sign a DEA Form 222. All information will be treated with strict confidence.

1. _____ _____ _____
Pharmacist's Name (Please Print) Title Pharmacist's License#

_____ _____
Signature Date

2. _____ _____ _____
Pharmacist's Name (Please Print) Title Pharmacist's License#

_____ _____
Signature Date

3. _____ _____ _____
Pharmacist's Name (Please Print) Title Pharmacist's License#

_____ _____
Signature Date