



PHARMACY RETAIL ACCOUNT APPLICATION

GENERAL INFORMATION:

Legal Company Name _____		Website Address _____		Federal Tax ID _____	
Legal Address (Main Office) _____		City _____		State _____	Zip _____
Primary Contact Name (we may call for questions regarding this application) _____		Title _____		Phone _____	
Billing / Statement Address (if different than the Main Office) _____		City _____		State _____	Zip _____
Accounts Payable Contact Person _____	Accounts Payable Telephone _____	Accounts Payable Fax _____	Accounts Payable Email Address _____		
Resale Tax Exemption Certificate # _____	<input type="checkbox"/> If you have more than one Resale/Tax Exemption Certificate, please list all that apply on the last page of this application. <input type="checkbox"/> Attach a copy of Resale/Tax Exemption Certificate(s) to the application.				

Are you a member of a GPO or Independent Buying Group? Yes No If yes, please list the name of the group: _____

SHIPPING INFORMATION:

DBA or Business Trade Name "Customer" _____	\$ _____	\$ _____	_____
	Estimated Monthly Purchases	Initial Order	# of Employees
Ship To Address _____	City _____	State _____	Zip Code _____
Shipping Contact Person _____	Shipping Contact Telephone _____	Shipping Contact Fax _____	Shipping Contact Email Address _____

OWNERSHIP:

Years in Business _____	State Org/Charter ID/License # _____	Name of State _____	Ownership Type: <input type="checkbox"/> Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Partnership <input type="checkbox"/> LLC
			<input type="checkbox"/> (S) Corp <input type="checkbox"/> Professional Corp <input type="checkbox"/> Non-Profit Corp

Identify the owner, shareholders, members, and officers of the legal entity:

Full Name _____	Title _____
Full Name _____	Title _____
Full Name _____	Title _____
Full Name _____	Title _____

REGULATORY IDENTIFIERS:

Medicare PTAN # _____	NP I# _____
<input type="checkbox"/> If multiple Medicare PTANs or NPIs, please list them all on the last page of this application.	

LICENSE AGREEMENT:

LICENSE AGREEMENT: Customer has and will maintain current, valid, and unrestricted licenses, permits, and/or certifications from the appropriate federal, state, and local agencies required to enable GEMCO Medical to sell to Customer and lawfully ship on its behalf those products to end users who buy from Customer.

Customer shall, at its own expense, obtain and maintain for each state or territory its required certifications, credentials, and/or licenses to distribute legend devices to end users, as well as permits necessary to conduct business for transactions contemplated under this Agreement. Customer will provide evidence of licenses, permits, and/or certifications as required for the distribution of prescription devices (i.e., Pharmacy, Wholesale Distributor, DME/HME). Please provide the following information (If multiple state licensures, please complete the license spreadsheet at the end of this application):

State _____	Name of Licensing Agency _____	License/Permit # _____	Effective From _____	Effective Through _____
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Customer agrees to immediately update GEMCO Medical with any renewals, changes, additions, suspensions, debarments, or terminations of any of its applicable licenses, permits, and/or certifications and to promptly notify Supplier should any restriction, suspension, or loss of any of its licenses, permits, and/or certifications occur.

The Customer also agrees to obtain and maintain current medical prescriptions from the prescribing health care providers before shipping the legend device or prescription-only products purchased from GEMCO Medical. The Customer agrees to provide evidence of a current medical prescription upon request from GEMCO Medical.

I agree that the above form is complete as applicable. (Note: This box must be checked before your application can be processed.)

PRIMARY BANK INFORMATION:

Bank Name _____	Bank Transit ABA# _____
Bank Address _____	Bank Account # _____
City _____ State _____ Zip _____	Bank Phone Number _____
Authorized Contact _____	Phone _____ Fax _____
Email Address _____	Alternate Contact Name & Phone _____

PREFERRED PAYMENT METHOD:

Please check one: PREPAY: EFT / ACH / Wire PAYMENT TERMS: EFT / ACH / Wire



TERMS AND CONDITIONS

GENERAL INFORMATION:

_____	_____	_____	_____
Legal Company Name	Customer DBA Name		
_____	_____	_____	_____
Legal Address (Main Office)	City	State	Zip

ACCOUNT AGREEMENT:

The undersigned submits this Account Application for consideration by GEM Edwards, Inc., dba "GEMCO Medical," and agrees to the following.

This Account Agreement ("Agreement") is expressly limited to the terms of this Agreement and the Purchase Order Transaction Terms contained in the applicable Purchase Order. The terms of this Agreement prevail over any terms or conditions contained in any other documentation related to the subject matter of this Agreement and expressly exclude any of Customer's general terms and conditions contained in any purchase order or other document issued by Customer, except the exhibits and schedules to this Agreement, the [Supplier Return Policy](#) (www.gemcomedical.com/return-policy), [Supplier Shipping Policy](#) (www.gemcomedical.com/shipping-options), and GEMCO Medical's ability to supply Products subject to manufacturer's supply and conditions of sale. Customer must submit timely, updated sales tax exemption forms to GEMCO Medical so that sales taxes are not charged on invoices issued to Customer. This Agreement prevails over any Customer's purchase order.

Prices are subject to change with 30 days' advance written notice. The most recent price list is available to Customers by logging into their accounts and supersedes any previously published price lists. All pricing and/or special considerations are dependent on the Customer's account being current within payment terms.

Please select one: 15-day cash payment terms: Invoices are due 15 days after the invoice date via ACH
 Other: _____

A finance charge of 2% will be assessed monthly on outstanding balances, which are 30 days past the invoice date. Orders will not be shipped on delinquent accounts. Any account balance paid by credit card after invoicing will incur a 2% processing fee. No processing fee will be assessed on payments made by check, electronic check, wire transfer, or money order. GEMCO Medical reserves the right to change or terminate open account credit at any time. If default of payment occurs, the Customer agrees to pay any and all attorney's fees and collection costs, up to and including asset seizure. The laws of the state of Ohio will govern the validity, effect, interpretation, and performance of this agreement.

The Court of Common Pleas in Summit County, Ohio, shall have exclusive jurisdiction over any suits, causes of action, or any other legal disputes between the parties, and/or their successors, which may arise under the terms of this Agreement and Guaranty. The undersigned expressly consents to the Court's jurisdiction.

Unless specified otherwise, all orders will be shipped in accordance with the GEMCO Medical Supplier Shipping Policy found at the link referenced above. Shipping charges will be added to your invoice. Shipments outside the continental U.S. will be billed accordingly. The Customer is responsible for any additional shipping charges due to the Customer supplying an incorrect shipping address.

Notification of shortages and/or damage must be made to GEMCO Medical's customer service team within three (3) business days of receipt, and missing packages within thirty (30) days of the ship date. To contact customer service via phone, please call 800-733-7976 or email customerservice@gemcomedical.com.

GEMCO Medical's Supplier Return Policy is found at the link referenced above. GEMCO Medical reserves the right to update the Return Policy from time to time.

Customer shall notify GEMCO Medical in writing no less than five (5) business days before any prospective or pending change in Customer's ownership interest in the company, or any change in the relationship of the signatories herein to the Customer. If GEMCO Medical is not notified, the current owner(s) shall be responsible for all balances due GEMCO Medical. GEMCO Medical reserves the right to require a signed promise to pay agreement by new owner(s).

I have read, understand, and on behalf of Customer agree to this Agreement. The undersigned has the authority to execute this Agreement on behalf of the Customer and hereby waives any right to assert lack of authority as a defense to any action by GEMCO Medical against Customer.

Notwithstanding GEMCO Medical's officer's signature below, the Agreement is not complete until all information and forms requested of Customer have been submitted to GEMCO Medical's satisfaction.

This section must be signed by a Corporate Officer, Partner, or Authorized Agent:

_____	_____
AUTHORIZED SIGNATURE	Print Name
_____	_____
Title	Date

GEM Edwards Inc. dba GEMO Medical:



David J. Lewis

CFO & Treasurer

Title



Additional License Addendum – Only Complete if Applicable.

ADDITIONAL LICENSES:

For multiple state or local licensures, please complete the form below for all that apply:

State	Name of Licensing Agency	License/Permit #	Effective From	Effective Through
State	Name of Licensing Agency	License/Permit #	Effective From	Effective Through
State	Name of Licensing Agency	License/Permit #	Effective From	Effective Through
State	Name of Licensing Agency	License/Permit #	Effective From	Effective Through
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State	Name of Licensing Agency	License/Permit #	Effective From	Effective Through
State	Name of Licensing Agency	License/Permit #	Effective From	Effective Through
State	Name of Licensing Agency	License/Permit #	Effective From	Effective Through

Attach a copy of the Licenses to the application.

Resale Tax Exemption Certificate– Only Complete if Applicable.

ADDITIONAL RESALE TAX EXEMPTION CERTIFICATES:

For multiple state resale tax exemption certificates, please complete the form below for all that apply:

State	Resale Tax Exemption Certificate#	Effective From	Effective Through
State	Resale Tax Exemption Certificate#	Effective From	Effective Through
State	Resale Tax Exemption Certificate#	Effective From	Effective Through
State	Resale Tax Exemption Certificate#	Effective From	Effective Through
State	Resale Tax Exemption Certificate#	Effective From	Effective Through
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State	Resale Tax Exemption Certificate#	Effective From	Effective Through
State	Resale Tax Exemption Certificate#	Effective From	Effective Through

Attach a copy of Resale/Tax Exemption Certificate(s) to the application.

Multiple PTAN and NPI Numbers – Only Complete if Applicable.

ADDITIONAL LICENSES:

For multiple PTAN and NPI Numbers, please complete the form below for all that apply:

State	Address	NPI #	PTAN #
State	Address	NPI #	PTAN #
State	Address	NPI #	PTAN #
State	Address	NPI #	PTAN #
State	Address	NPI #	PTAN #
State	Address	NPI #	PTAN #
State	Address	NPI #	PTAN #
State	Address	NPI #	PTAN #
State	Address	NPI #	PTAN #