



API

Associated Pharmacies, Incorporated

*Partner.
Purchase.
Profit.*

211 LONNIE E. CRAWFORD BLVD. • SCOTTSBORO, AL 35769 • PHONE: 800-243-8521 • FAX: 800-522-3335 • WWW.APIRX.COM

A Subsidiary of AAP

APPLICATION FOR ACCOUNT

INSTRUCTIONS TO APPLICANT: Please print or type. Fill in all spaces and complete by signing where indicated. If applicant is a corporation, limited liability company or limited partnership, the signature must be that of an authorized officer, member, manager or general partner. If applicant is a general partnership, the application must be signed by all partners. For the activation of your account and to ensure proper rebates, ALL information requested below must be completed and **copies of all licenses received.**

THIS FORM IS AN APPLICATION ONLY, NOT VALID UNTIL ASSOCIATED PHARMACIES, INC., ACCEPTS AND COUNTERSIGNS THE APPLICATION AND PERSONAL GUARANTY.

DATE ___ / ___ / _____

Salesperson _____

1. BUSINESS DATA

Applicant's/company's name _____ Fed tax ID# _____

D/B/A _____

Form of organization ___ Corporation ___ LLC ___ Partnership ___ Proprietorship

Physical address _____ Mailing address _____

Billing address, if different _____

City _____ State _____ Zip _____

Phone(____) ____ - ____ FAX(____) ____ - ____ Email address _____

*DEA # _____ NPI # _____ *State pharmacy license # _____

Dun & Bradstreet number _____ *Sales tax number _____

*** Copies of DEA license, state license and sales tax certificate must be received before your account can be activated.**

Owner(s) Information:

Name _____ Home address _____

City _____ State _____ Zip _____ What year did this person become an owner? _____

Name _____ Home address _____

City _____ State _____ Zip _____ What year did this person become an owner? _____

Name _____ Home address _____

City _____ State _____ Zip _____ What year did this person become an owner? _____

Date business established _____

Are you a member of another buying cooperative? ___ yes ___ no Which? _____

Average monthly purchases for resale from all vendors \$ _____

If AAP certificate holder, list certificate number _____

2. BANK REFERENCE

Name _____ Address _____
City _____ State _____ Zip _____ Phone _____
Account number _____ Account officer _____

3. TRADE CREDIT REFERENCES

Name _____ Address _____
City _____ State _____ Zip _____ Phone _____
Account number _____ Account officer _____

Name _____ Address _____
City _____ State _____ Zip _____ Phone _____
Account number _____ Account officer _____

Primary wholesaler _____ Account number _____

Previous wholesaler (if with current less than 1 yr.) _____ Account number _____

Does a bank, insurance company, or other creditor hold a security interest in your accounts receivable and/or inventory for loans advanced? ___Yes ___No

If yes, please state names of security interest holder(s) _____

4. FINANCIAL STATEMENTS / TAX RETURNS – Please attach copies of your Company’s two most recent fiscal year-end financial statements or tax returns.

5. DOCUMENT DELIVERY – How you would like to receive accounting documents from API

Invoices (in addition to the copy in shipment box) – check one:

- ___ Email – List email address, if different from page 1 _____
- ___ Fax – List fax number, if different from page 1 () _____ - _____
- ___ Don’t send another copy

Statements (sent twice per month) and credits issued – check one:

- ___ Email – List email address, if different _____
- ___ Fax – List fax number, if different () _____ - _____
- ___ Regular mail – API will add a service charge of \$2.00 per mailing

ACH/EFT (Electronic Funds Transfer) notifications of bank account debit – check one:

- ___ Email – List email address, if different _____
- ___ Fax – List fax number, if different () _____ - _____

6. PAYMENT METHODS (Choose ACH/EFT or FAX Check or Check by Mail):

ACH / EFT (Electronic Funds Transfer) Choose one –

Discount Terms

_____ Payment is due on Thursday of the calendar week following invoice date. Timely payment earns a .25% (1/4 of 1 percent) order discount

_____ Payment is due 10 days from invoice. Timely payment earns a .25% (1/4 of 1 percent) order discount.

Standard Terms

_____ Payment for products invoiced from the 1st through the 15th of the month is due on the 25th of that month.

_____ Payment for products invoiced from the 16th to the end of the month is due on the 10th of the following month.

ACH/EFT Credit/Debit Authorization

I hereby authorize Associated Pharmacies Inc. (THE COMPANY) to initiate debit entries to my checking account at the financial institution listed below (THE FINANCIAL INSTITUTION), and if necessary, initiate adjustments for any transactions credited in error. This authority will remain in effect until THE COMPANY is notified by me in writing to cancel it in such time as to afford THE COMPANY and THE FINANCIAL INSTITUTION a reasonable opportunity to act on it.

Signature (Must be listed on bank account signature card) (Complete bank account information below)

_____ FAX Check – Payment for products invoiced from the 1st through the 15th of the month is due on the 25th of that month. Payment for products invoiced from the 16th through the end of the month is due on the 10th of the following month.

FAX Check Authorization

I hereby authorize Associated Pharmacies, Inc. (THE COMPANY) to initiate fax checks at the financial institution (THE FINANCIAL INSTITUTION) listed below, and if necessary, initiate adjustments for any transactions credited in error. This authority will remain in effect until THE COMPANY is notified by me in writing to cancel it in such time as to afford THE COMPANY and THE FINANCIAL INSTITUTION a reasonable opportunity to act on it.

Signature (Must be listed on bank account signature card) (Complete bank account information below)

Bank Account Information for ACH/EFT or FAX check payment methods – Please attach a voided check

Name of Bank _____

Address of Bank _____

Bank Routing Number _____ Account Number _____

_____ Check by Mail – Payment for products invoiced from the 1st - 15th of the month is due on the 25th of that month. Payment for products invoiced from the 16th to the end of the month is due on the 10th of the following month.

7. APPLICATION PROVISIONS

As an inducement for Associated Pharmacies, Inc. ("API"), to accept orders from or otherwise extend credit or make available credit to the Applicant, the undersigned Applicant and Guarantor(s) hereby agree to the following, should API accept this application and elect to extend such credit:

1. Applicant and Guarantor(s) certify that the information provided by the Applicant and Guarantor(s) has been provided truthfully accurately and voluntarily.
2. Applicant and Guarantor(s) authorize API to investigate their creditworthiness, credit history and financial responsibility through any credit bureau and by any other reasonable means, including direct contact with past and present creditors. Applicant and Guarantor(s) also authorize banks and other financial institutions to give information to API about their checking and/or savings account(s) and loans. This authorization is valid for so long as Applicant continues to purchase products and/or services from API. A copy of this authorization may be accepted as the original.
3. If credit is extended as a result of this application, Applicant and Guarantor(s) agree to make payment promptly to API in accordance with its policies and practices and in accordance with any terms and conditions indicated on its invoices. In the event of non-payment, Applicant and Guarantor(s) hereby agree to pay, in addition to the invoiced amounts, any late charges, reasonable attorney fees, court costs and other related expenses arising therefrom.
4. Associated Pharmacies, Inc., reserves the right at all times to limit or terminate the extension of credit and to modify its terms of sale.
5. Associated Pharmacies, Inc., has permission to send announcements of product offerings, events, or any other information it deems appropriate to the email address, telephone number, or fax number listed on page one of this application.

All transactions between API and Applicant shall be governed by and construed in accordance with the laws of the State of Alabama, and the Articles of Organization and Bylaws of American Associated Pharmacies, a Minnesota cooperative and parent entity of API..

EXECUTED this _____ day of _____, 2_____.

Authorized signature _____

Printed name _____ Title _____

8. PERSONAL GUARANTY

The undersigned Guarantor(s) hereby request API to accept this application and to sell goods and/or services to the Applicant on credit. To induce API to take these actions, the Guarantor(s) agree to the terms above and jointly and severally, absolutely, unconditionally, and irrevocably guarantee to API and its successors and assigns the prompt and full payment (and not merely the ultimate collectability) and performance of all obligations of Applicant to API, whether now existing or hereafter arising. This is a continuing guaranty of all obligations, including those arising under successive transactions which shall either continue the obligations or from time to time renew them after they have been satisfied. This guaranty shall remain in effect until API actually receives and acknowledges written notice of its revocation as to future transactions, and even then, this guaranty shall be and remain effective as to obligations of the Applicant then outstanding. The Guarantor(s) hereby waive notice of acceptance hereof and the presentment, demand, protest, and notice of nonpayment or nonperformance or protest as to any note or obligation signed, accepted or delivered to API by the Applicant. The guaranty shall be binding on the Guarantor(s), their heirs, personal representatives, successors and assigns. The Guarantor(s) agree to pay reasonable attorneys' fees and all other costs and expenses which may be incurred by API in the enforcement of this guaranty. This guaranty shall be governed by and construed in accordance with the laws of the State of Alabama.

EXECUTED this _____ day of _____, 2_____.

_____	_____
Guarantor signature (must be owner)	Printed name
_____	_____
Guarantor signature (must be owner)	Printed name
_____	_____
Guarantor signature (must be owner)	Printed name

ASSOCIATED PHARMACIES, INC.
ACCEPTED BY _____ **Acceptance date** _____

9. REBATES

If and to the extent any discount, credit, rebate or other purchase incentive is paid or applied by API with respect to the Merchandise purchased under this Agreement, such discount, credit, rebate or other purchase incentive shall constitute a “discount or other reduction in price,” as such terms are defined under the Medicare/Medicaid Anti-Kickback Statute, on the Merchandise purchased by Applicant. Applicant agrees to use their best efforts to comply with any and all requirements imposed on sellers and buyers, respectively, under 42 U.S.C. § 1320-a7b(b)(3)(A) and the “safe harbor” regulations regarding discounts or other reductions in price set forth in 42 C.F.R. § 1001.952(h). In this regard, the Applicant may have an obligation to accurately report, under any state or federal program which provides cost or charge based reimbursement for the products or services provided by API, or as otherwise requested or required by any governmental agency, the net cost actually paid by the Applicant.

Pursuant to and in compliance with 42.C.F.R. § 1001.952(j), API hereby discloses to the Applicant that the fees paid to API under its Vendor Agreements are less than three percent of the total cost of the goods or services purchased by the Applicant under such Vendor Agreements.

10. COMPLIANCE AGREEMENT

Applicant agrees that it will abide by all applicable laws, rules, regulations, ordinances and guidance of the federal Drug Enforcement Administration (DEA), the states into which it dispenses controlled substances and the states in which it is licensed. Further, Applicant 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, Applicant agrees that it understands that Associated Pharmacies, Inc. (API) is required by DEA regulations to report to the local DEA Diversion field office any instances of suspicious orders of controlled substances. To that end, Applicant 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 prescriber 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.

Applicant agrees that if any potential red flags are identified, it is advisable to contact the prescriber 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.

Applicant acknowledges that API 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.

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

11. ASSIGNMENT

API may assign this Application or any membership that results therefrom to its parent entity, American Associated Pharmacies. Applicant shall not assign this Application or any membership that results therefrom without the prior written approval of API.

12. VENDOR AGREEMENTS

The Applicant authorizes API and its parent entity to negotiate and accept on the Applicant’s behalf, group purchasing agreements and other vendor agreements under which the Applicant will purchase pharmaceuticals, medical and other products, services, supplies and other wholesale and retail products (“Vendor Agreements”). The Applicant agrees to participate in and comply with the terms and provisions of Vendor Agreements entered into by API on the Applicant’s behalf. The Applicant further specifically authorizes API to accept payment of negotiated vendor rebates, incentives, administrative fees or other payments, the net amount of which is potentially subject to being distributed to all members of API as set forth in its Articles of Incorporation and Bylaws. The applicable terms of all Vendor Agreements are available for review on the secure website of apirx.com (member login required) and such terms are hereby incorporated into this Membership Agreement by this reference, including, but not limited to the fixed amounts or fixed percentages (of purchases made under Vendor Agreements) that shall be paid to AAP under each Vendor Agreement.

13. INDEMNIFICATION

The Applicant shall defend, indemnify, protect and hold harmless API, American Associated Pharmacies, and each of their affiliates, subsidiaries, officers, directors, employees, representatives, and agents (the "Indemnified Parties") for, from and against any and all claims, demands, actions, causes of action, suits, proceedings, hearings or investigations, and losses, liabilities, injuries, damages, costs and expenses incurred by any Indemnified Party to the extent caused by, arising out of, resulting from, attributable to or in any way incidental to the occurrence of any one or more of the following: (i) the Applicant's breach of the terms of this Application; (ii) inaccuracies in any of the information provided by the Applicant herein; and (iii) the Applicant's failure to comply with all applicable Federal and State Laws or licensure requirements.

14. CHOICE OF LAW

This Agreement shall be governed by the laws of the State of Alabama without regard to choice of law principles.

15. OFFSET

Applicant agrees to permit API to offset any negative balance amounts attributable to Applicant from receipts by or payments to API on behalf of the Applicant against any aggregate balance owed by API, or AAP or its subsidiaries, to Applicant or held for the benefit of Applicant.

Agreed to by a duly authorized officer, partner, or principal of Applicant.

Signature: _____

Full Name (print): _____

Title: _____

Date: _____

Revision date: 9/10/2009