PHARMACY PLUS PROGRAMS, LLC

APPLICATION FOR PARTICIPATING PHARMACY

PHARMACY NAME: _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE NUMBER: _____FAX NUMBER: _____

FEDERAL TAX ID NUMBER: _____

PHARMACY STATE BOARD OF PHARMACY LICENSE NUMBER: _____

DEA NUMBER: _____NBAP NUMBER: _____

PHARMACY OWNERSHIP:
SOLE PROPRIETORSHIP_ _PARTNERSHIP_ _ CORPORATION_ __

NAME OF "PHARMACISTS IN CHARGE": _____

PRIMARY WHOLESALER: _____

PHARMACY COMPUTER SYSTEM: _____

PERSON WITH AUTHORITY TO SUMBIT THIS APPLICATION ON BEHALF OF THE PHARMACY IDENTIFIED ABOVE MUST COMPLETE AND SIGN BELOW.

_____

PARTNER, OR CORPORATE OFFICER DATE

_____

PRINT NAME OF OWNER, PARTNER OR CORPORATE OFFICER TITLE

THE INFORMATION PROVIDED HEREIN IS CONFIDENTIAL. IT MAY NOT BE DUPLICATED OR PROVIDED TO OTHERS, UNLESS THOSE PERSONS/COMPANIES ARE SELECTED BY PHARMACY PLUS PROGRAMS, LLC, AS SUPPLIERS OF PRODUCTS AND /OR SERVICES TO THE PHARMACY NAMED ON THIS APPLICATION.

PLEASE RETURN APPLICATION WITH FIFTY DOLLAR ($50.00) FEE TO:

PHARMACY PLUS PROGRAMS
P. O. BOX 5805
MARYVILLE, TN 37802-5805