Credit Application

CuraScript SD Specialty Distribution

Billing and Shipping Information

Bill To (legal entity name)

Legal Address

Suite / Bldg / Floor / Mailstop

City | State | Zip

Billing Address

Suite / Bldg / Floor / Mailstop

City | State | Zip

Phone Number | Fax Number

Ship To

Shipping Address

Suite / Bldg / Floor / Mailstop

City | State | Zip

Phone Number | Fax Number

☐ Multiple shipping addresses (please attach a list of additional addresses)

Purchasing Contact | PC E-mail Address

Accounts Payable Contact | AP E-mail Address

Company Information

Business Type: ☐ Reseller/Distributor ☐ Closed Door Rx ☐ Open Door Retail Rx ☐ Treating Provider/Clinic

Organization Type: ☐ Corporation (type) ☐ Partnership (type) ☐ Sole Proprietor

Payer Mix: (Please enter percentage of each) ___% Medicare ___% Medicaid ___% Self-Pay ___% Other

Name on State License | Name on DEA License

State License Number (Please attach a copy) | Expiration | DEA License Number (Please attach a copy) | Expiration

Federal Tax ID Number/SS# | Years in business | Est. Avg. CuraScript Purchases ($)

Exempt from Sales/Use Tax: ☐Yes ☐No (Please attached a copy of your Sellers Permit and Resale Certificate)

Any voluntary liens of prior bankruptcies? ☐Yes ☐No (If yes, please provide the date, court & case number)

*Upon review of your application, you may be required to supply copies of your balance sheet, income statement and statement of cash flows.

Vendor and Bank References

Primary Drug Wholesaler | Account Number | Phone Number | Contact

Other Supplier | Account Number | Phone Number | Contact

Bank Name | Branch/Address | Checking Account Number

Bank Contact | Phone Number | Loan Account Number | Line of Credit Account number

*By completing the above information you are authorizing CuraScript SD to conduct a bank reference check.

By signing the below, I certify that I have received, read, understand, and agree to the Terms and Conditions provided to me with, or printed on the reverse side hereof and made part of this application.

Entity

Printed Name | Title

Signature (Must be signed by a Corporate Officer, Partner, Owner or Authorized Agent) | Date

Please Read and Retain For Your Records

CuraScript SD Specialty Distribution

Terms and Conditions

This application is submitted to Priority Healthcare Distribution Inc. doing business as CuraScript SD Specialty Distribution (hereinafter referred to as CSD) for the purpose of obtaining commercial credit. The undersigned represents and warrants that all information herein is current, correct and complete, and that CSD may rely on such information in deciding to extend or discontinue credit. The undersigned agrees to notify CSD immediately in writing of any change in the foregoing information including, without limitation, any change in the nature of business, ownership, name or location of the business or financial condition of the undersigned. The undersigned agrees to furnish current financial information from time to time as requested by CSD.

The undersigned acknowledges that before any credit purchases can be made, CSD must first approve this application and alternative forms of security may also be required. CSD may limit or discontinue any credit at its sole discretion. The undersigned authorizes CSD and any credit agency or investigatory service engaged by CSD to verify or otherwise investigate any information contained herein, or reference listed, statements, reports or other information obtained with respect to the undersigned from any other source, as CSD deems appropriate. The undersigned agrees to release all persons, companies or corporations using or supplying such information, including CSD, from any claims and/or losses that may result therefrom.

The prices for items purchased by the undersigned from CSD may include discounts or other reductions in price, and/or may be subject to subsequent rebates or other reductions or adjustments. By signing this credit application, the undersigned acknowledges that it must, to the extent required, report or reflect such discounts or reductions on cost reports or claims filed with federal or state health care programs, and the undersigned acknowledges that it should retain all CSD invoices and other documentation of discounts and make such information available to federal or state health care program officials upon request.

The undersigned understands and agrees that participating vendors (e.g., pharmaceutical manufacturers) from which CSD purchases goods may pay an administrative fee to CSD of 3 percent or less of the purchase price of the goods provided by that vendor. The administrative fee pays for services performed by CSD, such as the administration of chargebacks. If the undersigned is a health care "provider of services," which generally means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice program (see 42 U.S.C. § 1320a-7b(b)(3)(C)(ii) (citing the definition of "provider of services" at 42 U.S.C. § 1395x(u))), then the undersigned shall designate itself as such in writing to CSD, and CSD shall provide the undersigned with information, at least annually, and to the Secretary of the U.S. Department of Health and Human Services upon request, the amount received from each vendor with respect to purchases made by or on behalf of the undersigned. If you need additional information regarding administrative fees in order to comply with any legal reporting obligations you have, please contact CSD.

The undersigned agrees to pay in a timely manner all debts, accounts and invoices owing to CSD in full accordance with the agreed upon terms of sale as printed on invoices and that the due date for each invoice is the date by which payment must be received at the CSD "remit to" address noted on invoices and statements. The undersigned acknowledges that all statements of account shall be considered true and correct, unless the undersigned contests the accuracy of any such statement within 30 days of the date thereof, by sending a written inquiry to CSD. The undersigned agrees that in the event such debts, accounts or invoices are not paid when due, they will accrue late charges at the rate of eighteen percent (18%) per annum or the maximum rate allowed by law, whichever is the lesser rate. CSD reserves the right to apply any and all past-due moneys however it deems appropriate.

The undersigned agrees that: (1) this agreement shall be deemed fully executed and performed in the State of Florida and shall be governed by and construed in accordance with the laws thereof; (2) in any action, proceeding, or appeal of any matter relating to or arising out of this judgment, the undersigned shall be subject to jurisdiction of the State of Florida and accept venue in Seminole County, Florida; and (3) the undersigned expressly waives any right to a trial by jury. The undersigned agrees to reimburse CSD for any attorney fees, court costs or collection agency fees CSD may incur in its efforts to collect any past-due amounts.

Upon submission of this application to CSD and review by CSD of the same, the undersigned acknowledges that, prior to the extension of credit by CSD to the undersigned, CSD may require that the undersigned obtain a standby letter of credit in favor of CSD and/or a personal guaranty of one or more principals of the undersigned in favor of CSD (examples of each may be provided upon request). In addition to, undersigned may also be required to provide proof of legal entity.

Please complete the name of the entity on behalf of which this credit application is being submitted, print your full name, title/position, date, and sign in your official capacity on behalf of the entity.