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APPLICATION FOR DIRECT-PURCHASE ACCOUNT (Non-Distributor)

INSTRUCTIONS FOR COMPLETION:
Please complete all sections of this form. If a particular question is not applicable, please indicate with N/A. **Failure to complete this form in its entirety will result in a delay in processing and/or rejection of this application.**

Mail or fax the following items to the address listed below:

1. Completed and signed Application for Direct Purchase Account
2. Copies of all current state licenses and tax-exempt certificates

Mail or Fax to: Merck & Co., Inc.
Order Management Center, ZB-750
PO Box 4
West Point, PA 19486-0004

Fax # 215-631-5996
Attn: New Account Team
1-800-MERCK RX

Field Sales Personnel Only:
Name: _____
RDT: _____
MVX: _____
Cell: _____

If this Application for a Direct Purchase Account is approved, Merck & Co., Inc. will e-Mail your account number and most current price lists to the e-Mail address listed in the Account section.* ***If you prefer a hard copy mailed to you, please check here. _____**

Please keep a copy of this application for your records.

Name of Individual Completing this Form:	Role:	Phone Number:

SECTION I.

Type of Customer: (check appropriate box)

- ☐ Physician
- ☐ Physician Clinic
- ☐ Hospital Out-Patient Clinic
- ☐ Hospital
  - ☐ In-Patient Pharmacy or ☐ Out-Patient Pharmacy
- ☐ Fire Department
- ☐ Police Department
- ☐ Ambulance
- ☐ Health Department
- ☐ Research Facility
- ☐ Other _____ (*please describe*)

Type of Ownership: (check appropriate boxes, one from each column)

- ☐ Corporation
  - ☐ Private ☐ Public
- ☐ Individual
- ☐ Managed Care
- ☐ Federal
- ☐ City
- ☐ County
- ☐ State
- ☐ Other _____ (*please describe*)

- ☐ For Profit
- ☐ Not for Profit
- ☐ Partnership

Physician/Clinic Specialty:

- ☐ Dermatology
- ☐ Dialysis
- ☐ Emergency Medicine
- ☐ Family Practice
- ☐ Internal Medicine
- ☐ Ob/Gyn
- ☐ Pediatric
- ☐ Plastic Surgery
- ☐ Travel Clinic
- ☐ Other: _____ (*please describe*)

Tax Exempt (Local, County, State Sales Tax): ☐ Yes ☐ No

If you checked Yes, a tax exempt certificate must be attached or the account will be charged tax if shipping to a taxable state.

SECTION II.

Do you, any partners and/or owners, currently have or previously had a Merck account? ☐ YES ☐ NO

If you answered Yes, please provide the account information below. If you require additional space, please continue on a separate sheet of paper.

Account Name:	Account #:
Street Address:	Suite #:
City/State/ZIP:	
Area Code and Phone Number:	Area Code and FAX Number:

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SECTION III.

NAME OF OWNERSHIP:	
Street Address:	Suite #:
City/State/ZIP:	Company Website:
Area Code and Phone Number:	Area Code and FAX Number:
Contact Name:	Email Address:

LIST ALL OWNERS, OFFICERS AND/OR PARTNERS; INCLUDE COMPLETE ADDRESS AND PHONE NUMBER FOR EACH. PROVIDE A COMPLETE LIST OF OWNERS OF GREATER THAN 10% OF THE BUSINESS UNLESS IT IS A PUBLICLY-HELD COMPANY. (Please use a separate sheet of paper if more than two owners/officers/partners).

Name: _____	Name: _____
Function: (Owner/Officer/Partner): _____	Function: (Owner/Officer/Partner): _____
Address: _____	Address: _____
_____	_____
Phone Number: _____	Phone Number: _____

List all other trade or business names used by this facility (If not applicable, please note with N/A):

Name _____ Name _____

Bill To Name:	
Address:	Suite #:
City/State/ZIP:	How Long in Business?
Area Code and Phone Number:	Area Code and FAX Number:
Accounts Payable Contact Name:	Email Address:

Primary Shipping Location Name:	
Street Address:	Suite #:
City/State/ZIP:	
Area Code and Phone Number:	Area Code and FAX Number:
Contact Name/Phone Number:	Email Address:
Hours of Operation:	

IF ADDITIONAL SHIPPING LOCATIONS EXIST, PLEASE LIST THEM ON A SEPARATE SHEET OF PAPER AND PROVIDE THE LOCATION NAME, COMPLETE LOCATION ADDRESS, PHONE AND FAX NUMBERS AND A CONTACT NAME.

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PLEASE PROVIDE STATE LICENSE AND DEA LICENSE INFORMATION FOR A PHYSICIAN AT EACH LOCATION. A COPY OF THE CURRENT STATE LICENSE AND DEA LICENSE SHOULD ACCOMPANY THIS APPLICATION. (For physicians, only MD or DO state medical licenses will be accepted.) A COPY OF ALL CURRENT STATE MEDICAL LICENSES FOR ALL PARTNERS/OWNERS SHOULD ACCOMPANY THIS APPLICATION. IF LICENSED IN MORE THAN ONE STATE, PLEASE PROVIDE A COPY OF THE LICENSE FOR EACH STATE

State(s) License #(s):	License Type:	Name on License:	Expiration Date:
DEA License #:	Name on DEA:	Expiration Date:	Medical Education #:

SECTION IV.

Do you require a Purchase Order Number? □ YES □ NO Do you participate in any purchasing Contracts for Merck products? □ YES □ NO If you answered Yes, please list the contract number(s) and name:	Can you comply with the following storage requirements for Merck's products: YES NO Room Temperature (15-30C/59-86F) □ □ Controlled Refrigerated (2-8C/36-46F) □ □ Controlled Frozen (-20C/-4F or Colder) □ □
Do you import prescription pharmaceutical products? □ YES □ NO	If Yes, please list the country(s) you are importing from:
Do you export prescription pharmaceutical products? □ YES □ NO	If Yes, please list the country(s) you are exporting to:

SECTION VI.

What is the dollar value of your estimated monthly purchases of Merck products? $_____

Which Merck products do you plan on purchasing? _____

Have you purchased Merck products from a source other than Merck in the past 24 months? □ YES □ NO

If you answered Yes, from what sources were Merck products purchased? _____

SECTION VII.

To the best of your knowledge, have any of the applicants, owners, or persons listed on this application:

1. Been indicted or convicted of a felony on any federal, state, or local law? □ YES □ NO
2. Had a license, permit, registration denied, restricted, suspended, or revoked by any federal, state, or local government body? □ YES □ NO
3. Had ownership in a business that filed for bankruptcy or liquidation in the past seven years? □ YES □ NO

If you answered Yes to any of the above, explain in detail on an attached statement.

I affirm that all the information provided and the statements made on this application are true and accurate to the best of my knowledge. I agree to abide by all State and Federal laws regarding pharmaceutical and vaccine products. I understand that falsification of information provided may result in the rejection of this application or termination of a direct purchase account with Merck & Co., Inc.

If this application is approved and a direct-purchase account established with Merck & Co., Inc., I agree to purchase all Merck pharmaceutical and vaccine products directly from Merck or from a Merck Authorized Distributor.

_____
Signature of Officer or Owner

_____
Print Name/Title

_____
Date