APPLICATION FOR A DIRECT PURCHASE ACCOUNT (Non-Distributor)

Prescription Pharmaceutical and Vaccine Products Distributed by Merck Sharp & Dohme Corp. ("Merck")

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 may result in a delay in processing or rejection of this application.
Please keep a copy of this application for your records.

ONLINE REGISTRATION:
For Merck Vaccine customers, go to www.MerckVaccines.com and click on REGISTER. Once registered, the Application for a Direct Purchase Account (Non-Distributor) may be completed online.

For Merck Pharmaceutical customers, go to www.MerckOrders.com and click on REGISTER. Once registered, the Application for a Direct Purchase Account (Non-Distributor) may be completed online.

Fax or E-Mail the completed and signed Application for Direct Purchase Account form to the address listed below:		MERCK REPRESENTATIVE INFO:
If sending in by fax:	**If sending in by E-mail:**	Name: ______
FAX # - 215-616-9085	uscatdocumentation@merck.com	Cell: ______ E-Mail: ______

*If this Application for a Direct Purchase Account is approved, Merck & Co., Inc. will e-mail your Direct Purchase Account information to the e-mail address listed here: ** If you prefer to receive a paper copy, please check here* ☐ **

E-Mail:		
Name of the Individual Completing this form:	**Title:**	**Phone Number / extension**

SECTION I: - TYPE OF CUSTOMER & OWNERSHIP TYPE

A. Type of Customer	B: Type of Ownership	C: Tax Information
☐ Ambulance ☐ Chain Pharmacy ☐ Fire Department ☐ Grocer / Supermarket ☐ Health Department ☐ Hospital In-Patient Pharmacy ☐ Hospital Out-Patient Clinic ☐ Hospital Out-Patient Pharmacy ☐ Independent Pharmacy ☐ Mass Merchant/Retail Pharmacy ☐ Nurse Practitioner ☐ Other (please describe) ☐ Physician ☐ Physician Assistant ☐ Physician Clinic ☐ Police Department ☐ Research Facility	☐ City ☐ County ☐ State ☐ Federal ☐ Individual ☐ Managed Care ☐ Other (please describe) ☐ Private Corporation ☐ Public Corporation ☐ For Profit ☐ Not for Profit ☐ Partnership	**TAX Exempt** ☐ Yes ☐ No (Local, County, States Sales tax) (** If you checked Yes, a tax-exempt certificate must be attached or the account will be charged tax if shipping to a taxable state**) For Physician and Physician Clinic customers in GA, if you resell Vaccines and itemize the charges separately on the patient's bill, please attach a letter to the application with this statement. For customers in HI, please submit a G17 form. For customers in IL, LA, MN, and SC please submit a tax exempt certificate. Not applicable for any other states.

SECTION II– OWNERSHIP INFORMATION

Please provide your ownership information below.

A. NAME OF OWNERSHIP -

Street Address:	Suite #
City /State/Zip:	Company Website:
Area code and phone number:	Area code and FAX number:
Contact Name / Phone Number(if different)	E-mail address:

List all owners, officers and/or partners: Include your complete address and phone number for each owner listed below. A complete list of owners of greater than 10% of the business should be listed, unless it is a publicly-held company.
(Please use a separate sheet of paper if you have more than 2 owners/officers/partners).

B. Name:	Name:
Function: (Owner/officer/partner :)	Function: (Owner/officer/partner :)
Address:	Address:
Area code & Phone Number	Area code & Phone Number:

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

SECTION III – CURRENT or PREVIOUS CUSTOMERS

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 answered No, please go to Section IV.

Account Name:	Current or Previous Account Number:
Street Address:	Suite #
City /State/Zip:	

SECTION IV – NEW CUSTOMER BILL TO:

Please provide name and address to which the invoice should be sent.

Bill To Name: ☐ **Same as OWNERSHIP NAME AND ADDRESS**

Street Address:	Suite #
City /State/Zip:	How Long in Business?
Area code and phone number:	Area code and FAX number:
Accounts Payable Contact Name	E-mail address:

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SECTION V – NEW CUSTOMER SHIP TO:	
If you would like more than one ship to address for this account, please list them on a separate sheet of paper and provide: Location name, location address, phone and fax number, a contact name and license information.	
☐ Check here if your BILL TO address is the same as your SHIPPING address.	
Shipping Location Name:	
Street Address:	Suite #
City /State/Zip:	How Long in Business?
Area code and phone number:	Area code and FAX number:
Contact Name / Phone Number(if different)	E-mail address:
If the location is not open yet, please provide the opening date:	

SECTION VI - DELIVERY HOURS
Please list the hours that you **CANNOT accept** deliveries.

SECTION VII– PRICING CONTRACTS		
Do you participate in any purchasing contracts for Merck products through a Group Purchasing Organization, Physician Organization, or on a Merck contract?	☐ Yes ☐ No	If YES, please list the contract name:

NOTE: In addition to completing this section, an enrollment form may also be required in order to be eligible for contracted pricing for Merck Products. Please check the Terms and Conditions of your purchasing contract or pricing program for further guidance. Failure to complete this section and any required enrollment forms may result in the location not being linked to any purchasing contracts for Merck Products.

For questions related to Merck Contracts and Pricing Programs, contact the Merck Vaccine Customer Center for vaccines at 1-877-829-6372 or the Merck Order Management Center for pharmaceuticals at 1-800-637-2579.

SECTION VIII – LICENSE INFORMATION				
Please provide the state license information for a physician at each shipping location. If licensed in more that one state, please provide a license for each state.				
State(s) License #(s):	State:	License Type:	Name on License:	Expiration Date:

SECTION IX – OFFICE INFORMATION		
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:
Do you have Controlled Refrigerated storage?	☐ Yes ☐ No	(2° to 8°C/36° to 46°F)
Do you have Controlled Frozen storage?	☐ Yes ☐ No	(-15°C/5°F or Colder)

SECTION X – OWNER CONFIRMATION & SIGNATURE

To the best of your knowledge, have any of the applicants, owners, or persons listed on the 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 of a business that filed for bankruptcy or liquidation in the past 7 years? ☐ Yes ☐ No

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 is established with Merck & Co., Inc., I agree to purchase all Merck pharmaceutical and vaccine products directly from Merck or from a Merck Authorized distributor, and to adhere to Merck's current terms and conditions of sale.

____
Signature of Authorized Representative

____
Print Name and Title

____
Date