MERCK

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.

Mail or Fax the following items to the address listed below: 1. Completed and signed Application for Direct Purchase Account form 2. Copies of all current state license and tax exempt certificates		MERCK REPRESENTATIVE INFO: Name: _____ Cell: _____ E-Mail: _____
If sending in by fax:	**If sending in by mail:**	
FAX # - 215-616-9085 **215-631-5996**	Merck & Co., Inc. Customer Accounts Team 1180 Church Rd - ZB-750 Lansdale, PA 19446	

*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: - CUSTOMER TYPE and OWNERSHIP TYPE		
A: Type of Customer	B: Type of Ownership	C: Detail of Ownership
☐ Physician ☐ Physician Clinic ☐ Hospital Out-Patient Clinic ☐ Physician Assistant ☐ Nurse Practitioner ☐ Hospital In-Patient Pharmacy ☐ Hospital Out-Patient Pharmacy ☐ Chain Pharmacy ☐ Independent Pharmacy ☐ Grocer / Supermarket ☐ Research Facility ☐ Mass Merchant ☐ Retail ☐ Police Department ☐ Fire Department ☐ Health Department ☐ Ambulance ☐ Other (please describe) _____	☐ Corporation – Private ☐ Corporation – Public ☐ Individual ☐ Managed Care ☐ Federal ☐ City ☐ County ☐ State ☐ Other (please describe) _____	☐ 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, OH, SC, and WV, please submit a tax exempt certificate. Not applicable for any other states.

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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:

SECTION VI– 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:

Failure to complete this section may result in the location not being linked to any purchasing contracts for Merck Products.
For questions related to Merck Contracts and Pricing Programs,
Please contact the Merck Vaccine Customer Center at 1-877-829-6372.

SECTION VII - DELIVERY HOURS

Please list the hours that you **CANNOT accept** deliveries. Please indicate if you close for lunch and not able to accept deliveries.

SECTION VIII – LICENSE INFORMATION

Please provide the state license information for a physician at each shipping location. A copy of the current state license must accompany this application. (For physicians only MD and DO will be accepted). A copy of all current state licenses for all partners/owners should accompany this application. 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:
*DEA License # (Optional)	*State:	Med Education #	* Name on DEA:	Expiration Date:
HIN Number (Optional)				

***By providing and submitting DEA license number on this Account Application Form, Applicant authorizes Merck & Co., Inc. to release the DEA registration number provided above as necessary to process transactions.**

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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– Optional - www.Merckvaccines.com Registration

- For Merck Vaccine customers, go to www.Merckvaccines.com. and click on **REGISTER**

Create a user name and password. Supply your registered www.merckvaccines.com user name in the space provided below. We will link your Direct Purchase Account to your user name. You will then have access to make vaccine purchases, pay bills, and access other account management features that www.merckvaccines.com offers.

Merck Vaccines User name: _____

SECTION XI– 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 officer or owner

_____
Print Name and Title

_____
Date