2000 West 135th Street, Gardena, CA 90249 P (800) 438-2568, F (310) 220-2917,
info@dvmed.com, www.dvmed.com

NEW ACCOUNT CHECKLIST FOR PHARMACY
NON-CONTROL ONLY ACCOUNT

- **PHARMACY QUESTIONNAIRE**
  - Must be complete
  - Must be legible
- **LICENSES**
  - State Pharmacy Licenses (Licenses must be to shipping address, and must be legible)
    - Pharmacy license
    - Pharmacist in Charge license
  - Resale Permit and CA Resale Certificate
- **PICTURES OF PHARMACY- please email**
  - Front of Building (must show signage with name of pharmacy)
  - Front Door (must show hours of operation)
  - Waiting area
  - Dispensary
  - Security System
- **PHOTO ID - please email**
  - Copy of photo ID of Pharmacist in Charge
  - Copy of photo ID of Owner of Pharmacy
- **REGULATORY**
  - Most recent Inspection Report from the Board of Pharmacy (new pharmacy submits preliminary report)
- **DISPENSING HISTORY - please email**
  - 6-Month Drug/Prescription Dispensing Report
- **MISCELLANEOUS (upon request)**
  - Copies of written Policies and Procedures
  - Resume of Pharmacist in Charge
  - Copy of Building Lease (First Page and Signing Page)
  - Corporate of State Business Documents providing Ownership information

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Pharmacy Questionnaire

*** Please fill out completely. Questionnaires returned with blank spaces or unanswered questions will be returned for completion. If a question does not apply, write "N/A" in the space***

SECTION 1: General Information **Rep: _____**

1. Referred by: _____

2. Pharmacy Legal Name and DBA (if any):_____

3. Pharmacy Address: _____
Street Name City State Zip Code

4. Billing Address: _____
Street Name City State Zip Code

5. Pharmacy Email and Web Address: _____

6. Pharmacy Phone Number: _____

7. Pharmacy Fax Number: _____

8. Purchaser Name and phone number: _____
Name Phone Number

9. Has the pharmacy ever operated under a different name? ___ Yes ___ No

a) If yes, what name(s)? _____

10. Full Name of Pharmacist in Charge: _____

11. Number of years in business: _____

12. Pharmacy Hours: _____

13. Days Open: ___ Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday ___ Saturday ___ Sunday

14. State Board of Pharmacy License Number: _____ Expiration Date: _____

15. State Registration Category: ___ Retail ___ Chain ___ Central Fill Pharmacy ___ Wholesaler ___ Other

16. Provide details of any other applicable licenses and associated numbers: _____

17. Is the pharmacy a member of any professional organizations (NABP, NCPA, APHA, ETC.)? ___ Yes ___ No

a) If yes, please list. _____

18. Does the pharmacy have any other certifications (VIPPS, ETC)? ___ Yes ___ No

a) If yes, please list. _____

19. When was the pharmacy last inspected and by whom? _____

a) Please attach a copy of the last inspection report and your responses

SECTION 2: Ownership

20. Ownership Type (check one) ___ Sole prop ___ Corp ___ Partnership ___ LLC ___ Other

21. For corporations, indicated the state of incorporation: _____

22. Owner(s) name (Corporate Officers if corporation): _____

23. Owner(s) Business Address: _____

_____

24. Owner(s) Phone: _____

25. Owner(s) Fax: _____

26. Owner(s) Email: _____

27. Number of years owner has operated the pharmacy: _____

28. Are any of the owners not a licensed pharmacist? ___ Yes ___ No

29. Do any of the owners operate/own any other pharmacies? ___ Yes ___ No

SECTION 3: Prior History

30. Has any pharmacist associated with the pharmacy ever been sanctioned by regulatory agency: ___ Yes ___ No

a) If yes, provide details: _____

31. Has the pharmacy ever had its state licenses suspended or revoked? ___ Yes ___ No

a) If yes, provide details: _____

32. Do you conduct background checks on all employees? ___ Yes ___ No

33. Do you conduct drug screens of employees? ___ Yes ___ No

SECTION 4: Other Business Information

34. Is the pharmacy a closed door pharmacy? ___ Yes ___ No

35. Is the pharmacy located within a medical center? ___ Yes ___ No

36. Are you in close proximity to one or more medical facilities such as a hospital or large clinic?

Doctor's Offices: ___ Yes ___ No Medical Clinics: ___ Yes ___No Hospital: ___ Yes ___ No

a) If yes, identify name, type, address, proximity to pharmacy:

_____

37. Is the pharmacy affiliated with any other pharmacies? ___ Yes ___ No

a) If so, please explain and list affiliates: _____

_____

38. Does the pharmacy have security guards on the premises? ___ Yes ___ No

a) If yes, provide reason: _____

_____

39. How many prescriptions does the pharmacy fill on an average daily basis? _____

40. How does the pharmacy receive payment for products and in what approximate percentage?

a) Insurance % of Revenue _____

b) Medicare/Medicaid % of Revenue _____

c) Cash/Credit/ Debit Card % of Revenue_____

d) Other _____ % of Revenue _____

41. What percentage of the pharmacy's business is attributable to each of the following?

Regular Customers: _____% Hospice: _____%

Long Term Care Facility: _____% Other: _____%

42. Does the pharmacy supply, order for, or sell to any practitioners or other pharmacies? ___ Yes ___ No

43. Does the pharmacy offer a full range of sundries? ___ Yes ___ No

SECTION 5: Miscellaneous Information:

44. Does the pharmacy fill prescriptions for out-of-state patients? ___ Yes ___ No

a) If yes, to what extent? Explain: _____

_____

45. Please provide names of all suppliers you have used within the last 24 months:

Name of Supplier:	Non-Controlled RX	Controlled RX	Total
1.	%	%	100 %
2.	%	%	100 %
3.	%	%	100 %

46. What procedures do you use to verify practitioners DEA and state board licenses? _____

_____

47. What procedures do you use to insure prescriptions are issued in normal course of a legitimate medical practice?

_____

_____

48. Has the pharmacy ever refused to fill prescriptions for a particular practitioner? ___ Yes ___ No

a) If yes, why and whom? _____

49. Is the pharmacy comfortable with the prescribing practices of all of the practitioners for which it fills prescriptions? ___ Yes ___ No

50. Are the prescriptions written by physicians located in the state in which the patients reside? ___ Yes ___ No

Any changes in ownership, location, pharmacy or pharmacist-in-charge licenses shall be reported to the staff at DV Medical Supply, Inc. immediately. I declare under penalty of perjury that the foregoing is true and correct:

_____ _____ _____

Signature (DEA License Holder) Title (DEA License Holder) Date

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Account Terms & Conditions

Credit Card payment is due prior to shipment.

Customer agrees to jurisdiction and venue in Los Angeles, California for all disputes relating to or arising from the purchase of products from DV Medical Supply.

Quotation and pricing are subject to change based on the availability of products, as well as price fluctuations by vendors of DV Medical Supply, Inc. All special orders are non-refundable and non-returnable upon placing the PO.

In the event there is a shortage or discrepancy found after delivery of products, customer agrees to notify vendor within 48 hours of receipt of goods. After the 48 hour period, customer waives any and all claims with regard to such shortage or discrepancy and agrees to pay invoice in full.

Customer agrees that all sales are final and that goods received are non-returnable.

Should any provision herein be determined to be void, invalid, unenforceable or illegal by a court, the validity and enforceability of the other provisions shall not be affected thereby.

We reserve the right to refuse to do business with anyone including, but not limited to, the following: those who do not possess a valid home state license or DEA registration (if applicable), those that have had prior convictions, or those not found to be in good standing with their licensing board.

By submitting this application the undersigned acknowledges that the information provided is accurate and true to the best of their knowledge and agrees to receive faxes and/or emails to the above-listed contact.

The undersigned affirms and represents that they are authorized to execute these "Terms & Conditions" on behalf of this customer.

Signature: _____ Title: _____

Name (print): _____ Date: _____

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other
Cardholder Name (as shown on card): _____
Cardholder Title_____
Corporate: ☐Yes ☐No
Card Number: _____
CVV Code:_____
Expiration Date (mm/yy): _____
Cardholder Billing Address:_____
Cardholder Phone Number: ( )
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize DV Medical Supply, Inc. to charge my credit card above for agreed upon purchases. I understand that my information will be saved on file for future transactions on my account.

_____
Cardholder

_____ _____ _____
Print Name Title Date