



GeriMed Mini-Application

Pharmacy Name: _____

Address: _____

City, State, Zip: _____

Phone#: _____ Fax#: _____

Contact Name: _____ Title: _____

DEA#: _____ NCPDP#: _____

NPI#: _____ E-Mail: _____

Number of Beds: _____ On Site: _____ Off Site: _____

If off site, number of nursing home serviced: _____

Number of skilled and intermediate care beds serviced: _____

Home Care Services, average number of patients serviced per month: _____

Jails and prisons, average number of patients serviced per month: _____

Hospice, average number of patients serviced per month: _____

Assisted Living, number of beds serviced: _____

Number of other types of patients serviced: _____

Psychiatric group homes/chronic psychiatric facilities: _____

Wholesaler (Primary)
(include city/state of location): _____

Wholesaler (Secondary)
(include city/state of location): _____

Pharmacist In-Charge: _____

Director of Operations: _____

Purchasing Agent: _____

A list of all facilities serviced must be attached. Include name of home, street address, telephone number and number of licensed beds for each facility. This is a requirement to receive pricing from several manufacturers.

Enclosures required:

- Copy of DEA Certificate
- Copy of Pharmacy Permit
- Copy of State Registration
- List of Long Term Care Facilities Serviced

AGREEMENT FOR USE OF
GERIMED PROGRAM CONTRACT

Name of Client: _____

Address: _____

I certify that the above-named Client is not engaged in retail sales and that all items purchased through the GeriMed Program will be utilized consistent with the established guidelines based on United States Supreme Court decision in **Abbott Laboratories, et al, vs. Portland Retail Druggists Association, et al.** As used herein, any and all merchandise purchased under this program shall be for our own use. The phrase "own use" is limited to the following:

1. Dispensing of the product to inpatients or emergency patients for treatment at the facilities serviced by the client.
2. Dispensing of the product to former patients upon their discharge as take-home prescriptions or supplies necessary for a limited and reasonable time as continuation of treatment;
3. Dispensing of the product to Client employees or employees of the facilities serviced by the Client for their own use or the use of their dependents (but not for the use of their non-dependent family members); or
4. Dispensing of the product to a staff member physician in a facility serviced by the Client for his or her personal use, or for the use of his or her dependents (but not other persons or for use in the physician's private practice).

I further represent and warrant that this Pharmacy shall not buy, distribute, sell, transfer, or use contract bid priced products or cause the distribution of bid priced products in any manner contrary to the requirements of "own use" or any terms and conditions contained in this document. I grant to GeriMed and/or its suppliers all rights and legal remedies including, but not limited to, (a) the right to seek contribution to any judgment or (b) the right to recover the difference between retail price and bid price on any product sold or distributed contrary to the "own use" requirements or these terms and conditions. Further, I understand that the Prescription Drug Marketing Act of 1987 imposes severe criminal penalties for any such violations.

It is understood that this is a continuing certification and that the Client will hold GeriMed and its suppliers harmless from any action or judgement arising from the Client's failure to comply with its restrictions.

Date

Authorized Name (Print or Type)

Signature