

SAMPLE



Form # bg0007

Revision: 02/08
Supersedes: 02/06

Akorn, Inc.
2500 Millbrook Drive
Buffalo Grove, IL 60089
Fax # 800-943-3694

CUSTOMER ACCOUNT AND CREDIT APPLICATION

1. DEA LICENSE # / STATE LICENSE # (REQUIRED):

RM 0339831

2. DEA / STATE LICENSE EXPIRATION DATE (REQUIRED):

1/31/2009

****IMPORTANT! ATTACH COPIES OF REQUIRED FORMS (DEA CERTIFICATE AND/OR STATE LICENSE AND TAX EXEMPT FORM)****

3. BILL TO NAME / ADDRESS:

CA Department of Health
221 Nowhere Lane

City: NoPlace

State: CA Zip: 22211 County:

Phone: (510) 123-4567

Fax: (510) 123-5476

Purchasing Contact Name: Dick Tracy

4. SHIP TO NAME / ADDRESS:

McKesson Specialty Distribution
4853 Crumpler Road

City: Memphis

State: TN Zip: 38141 County:

E-Mail Address: dick.tracy@ca.us.gov

Accts. Payable Contact Name: Betty Boop

5. MEMBERSHIP:

If member of GPO or Buying Group, please identify membership:

Do you wish to have your Akorn purchases billed to your membership? Yes No

6. TYPE OF BUSINESS:

Corporation Partnership Sole Proprietor (Social Security # _____) Other (Specify) State gov't

7. DEFINE OPERATION (CHECK ONLY ONE):

Hospital or Hospital Pharmacy Surgery Center or Cataract Surgeon EMS (Emergency Medical Services) Retail Chain or Grocery

Retail Pharmacy Research Facility or University Industrial (Poison Control Products Only) Urologist Rheumatologist

Retinal Specialist Ophthalmologist (Not a Retinal Specialist) Optometrist

Distributor (If Distributor, do you export? Yes No) Other (Please Specify): State government

8. PRINCIPALS:

NAME	POSITION	HOME ADDRESS	PHONE #
<u>Daffy Duck</u>	<u>Vaccine Manager</u>		<u>(510) 222-3333</u>
<u>Donald Duck</u>	<u>Vaccine Ordering clerk</u>		<u>(510) 222-4444</u>

9. BANK REFERENCE:

Bank Name: Anywhere BANK

Account #: 0012345678

Address: Gotham City,

Phone: (510) 231-6789

10. TRADE REFERENCES (Minimum of 3): N/A

NAME	ADDRESS	PHONE #	FAX #
<u>N/A</u>		()	()
		()	()
		()	()

11. CREDIT LIMIT REQUESTED: N/A

Credit Limit Needed: \$ _____ / Need Monthly Statement? Yes No

The undersigned agrees to pay any balance after thirty (30) days and all actual attorney fees and costs of collection: personally guarantees all payments and unconditionally waives the right to any amount paid pursuant to this provision. The undersigned hereby consents to the confirmation by company, and its divisions of the information contained herein and authorize Akorn Inc. to contact the undersigned bank and suppliers listed herein and obtain the necessary credit reports. Terms of sales have been fully explained and I understand that if an account is established, my credit line is subject to periodic review. Also, shipments may be held if my account is delinquent or exceeds my established line of credit. The undersigned authorizes company to take appropriate measure to verify the credit of the undersigned and releases company from any obligation while researching this information.

12. SIGNATURE: N/A

Your Signature: _____ Title: _____ Date: _____

OFFICE USE ONLY

Credit Limit: \$	Date Approved:	Signature:	CR #
Terms:	Acct #	Sales Rep:	Discount:

This document can be found on the CDC website at:

<http://www.cdc.gov/vaccines/programs/vmbip/downloads/agm/sam-aca-form.pdf>