MAKSPHARMA AND DIAGNOSTICS INC

Tel : 516-323-1255 | Fax: 866-266-1217
Admin@MaksPharma.com | www.MaksPharma.com
2365 Milburn Ave, Bldg. #2, Baldwin, NY 11510-1711

CREDIT APPLICATION

BUSINESS CONTACT INFORMATION

TYPE OF BUSINESS: ☐ RETAILPHARMACY ☐ ONLY WHOLESALER ☐OTHER (PLEASE SPECIFY) ____________________

Company Name		Date business commenced: ____________
D/B/A OR Formerly Know As Names		CORPORATE STRUCTURE ☐ Sole proprietorship ☐ Partnership ☐ Corporation ☐ Other
Phone | Fax		
E-mail		
DUNS Number		

Tax ID Number		**Contact Person**	
Registered company address City, State, Zip		Name	
Shipping Address City, State, Zip		Phone Fax	
Billing Address City, State, Zip	☐ Check here if Billing Address is as same as Shipping Address	Email	
		Job Title	

BUSINESS/TRADE REFERENCES

Company name		Phone	
Address		Fax	
City, State ZIP Code		E-mail	
Type of account		Other	
Company name		Phone	
Address		Fax	
City, State ZIP Code		E-mail	
Type of account		Other	

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Company name		Phone	
Address		Fax	
City, State ZIP Code		E-mail	
Type of account		Other	

BANK REFERENCE

Bank Name		Phone & Contact Name	
Address		Fax	
City, State ZIP Code		E-mail	
Type of Account	☐ Savings ☐ Checking ☐ Other	Account Number	

OWNER(S) INFORMATION

(Use Additional Sheets if Needed)

Name	Title	Pharmacist (Yes/No)	License No. & State (If Applicable)	Work Location (Address)

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SUPERVISING PHARMACIST INFORMATION

(Use Additional Sheets if Needed)

Name	License No.

BUSINESS INFORMATION

Do you own any other Pharmacy and/or Pharmaceutical Wholesale Business? (YES / NO)
If yes, please indicate below (use additional sheets if needed):

Name of Company	Address	License No.	Has your License ever been suspended/revoked?
			YES/NO
			YES/NO

1. Have you ever been enjoined, disciplined, fined, punished, or the like for violating any federal or state laws regulating prescription drugs or devices? (YES / NO)
2. Have you ever been found guilty, pled guilty, or pled nolo contendere to any criminal offense? (YES / NO)
3. Can you comply with all applicable statutes and regulations governing wholesale distribution where licensed or registered and comply with the more stringent law or regulation as determined by conflicts of law rules? (YES / NO)
4. Have you ever engaged in the unlawful distribution of prescription drugs? (YES / NO)

EXPORT RESTRICTIONS

The merchandise purchased from MAKS PHARMA AND DIAGNOSTICS INC cannot be exported for the purposes of RLD, relief work, individual patients, and/or distributing without authorization of MAKS PHARMA AND DIAGNOSTICS INC.

AGREEMENT

1. All invoices are to be paid by ACH agreement 21 days from the date of the invoice or on the same day to your credit card based on the option selected
2. Claims arising from invoices must be made within seven working days.

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3. By submitting this application, you authorize **MAKS PHARMA AND DIAGNOSTICS INC** to make inquiries into the banking and business/trade references that you have supplied.
4. All vendor and customer licenses will be verified annually using data from appropriate state and federal agencies to verify identity, legitimacy, and proper operation of entities seeking to sell or purchase prescription drug and device products, including the verification that trading partners are authorized pursuant to federal law.
5. By signing below, you agree with **MAKS PHARMA AND DIAGNOSTICS INC's** *Export Restrictions* listed in the application above and answered all questions pertaining to licensure and businesses truthfully and all other information provided is true.
6. Please sign below and submit with a copy of State License and DEA.

SIGNATURES OF OWNER(S)

(Use Additional Sheets if Needed)

Signature		Signature	
Name and Title		Name and Title	
Date		Date	

CONSENT TO FAX/EMAIL:

The information provided in this application will not be sold or shared with anyone. All information obtained will remain ONLY with Maks Pharma and Diagnostics Inc. Maks Pharma and Diagnostcs Inc. is committed to staying current with our customers' needs. We are aware that most of our customers would prefer to do all business through an E-Mail system or via fax or both.

With that in mind, we ask that you take a moment to complete the following and give us the most current e-mail address and fax number(s) needed when communicating with you.

Fax Number:____________________ Secondary Fax Number: (if any):____________________

Designated E-mail Address: ______________________________
(To be used to electronically deliver policies, applications, and/or other contract related correspondence such as cancellations, approvals, etc. to your office.)

By signing below, I am authorizing and hereby consent to receive faxes and emails sent by or on behalf of Maks Pharma and Diagnostics Inc.

____
Signature of authorized company representative ***Title*** ***Date***

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Recurring/Backup Payment Authorization Form

Schedule your payment to be automatically deducted from your bank account, or charged to your Visa, MasterCard or American Express. Just complete and sign this form to get started! Email completed form to ar@makspharma.com OR Fax to 866-266-1217.

NET 30-CHECK ☐ Check paying customers must list a **backup** form of payment below.

Recurring/Backup Payment Terms:

You authorize charges to your bank account or credit card. Recurring payments will be collected for open invoices on your account each billing period. A receipt will be emailed to you and the charge will appear on your bank statement. Customers whose checks are not received within 15 days of due date will have their backup form of payment charged. Credit Card payments are collected at Point-of-Sale. **No prior-notification will be provided for any form of payment.**

Please complete the information below:

Medical Facility or Pharmacy Name: ____

Billing Address City, State, Zip: ____

Phone Number:______________________ Email (required): ____________________

Checking/ Savings Account

☐ Checking ☐ Savings

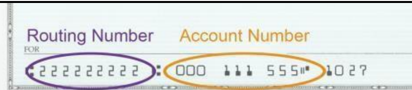
Name on Acct: ________________________

Bank Name: ________________________

Account Number ________________________

Bank Routing # ________________________

Bank City, State ________________________



Credit Card

☐ Visa ☐ MasterCard

☐ Amex

Business Cardholder Name as It Appears on the Card:

____

Card Number: __________________________

Exp. Date:__________CVV: _________

Billing Address: ______________________________

City: ________________________ State: _______

Zip: ______________

A 3.5% fee will apply when using a credit card

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify MAKS Pharma and Diagnostics Inc in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that MAKS Pharma and Diagnostics Inc may at its discretion attempt to process the charge again within 30 days and agree to an additional $50 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card Company; so long as the transactions correspond to the terms indicated in this authorization form.

Print Name______________________**SIGNATURE**________________________**DATE:**__________

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AFFIDAVIT OF COMPLIANCE

STATE OF ________________
COUNTY OF ____________________

(COMPANY)
(COMPLIANCE MANAGER NAME)
(ADDRESS)
(PHONE)
(FAX)
(EMAIL)

The undersigned, _______________________, hereby agrees and says:

1. The products purchased from Maks Pharma and Diagnostics Inc, will only be dispensed to the end user (patients).
2. The pharmacy will not obtain or have a wholesale distributing license.
3. The pharmacy will provide complete and accurate Transaction Data; will use Direct Purchase Statements only when applicable; and will cooperate with Maks Pharma and Diagnostics Inc to verify and validate Transaction Data when requested.

____
Compliance Manager / CEO/ President

Maks Pharma and Diagnostics Inc will not accept returns for any repackaged products, free goods or items sold as non-returnable such as close outs and short dates / products expiring within 6 months.

#redits will be issued within 14 business days from receipt of the returned items. Credit issued may be used towards any future purchases; you will not be issued credit in the form of check/cash.

NAME: ____________________________ SIGNED: ______________________________ DATE:_______________

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Pharmacy Information:

Authorized Purchaser(s) Name / Title:

Hours of Operation

MON	TUE	WED	THU	FRI	SAT	SUN

(OPTIONAL INFORMATION)

Wholesalers Info (Please Circle all applicable)

Amerisource Bergen/ Bellco HD Smith McKesson Cardinal Health Kinray Rochester Drugs Corp (RDC)

Anda Parmed Harvard Masters Rivercity Top Rx IPC

Please Name any other generic wholesalers you are currently doing business with……………………………………………………

……

Do you buy online through any of the following?

Trxade Pharmsaver EzriRX Other:____________________