Tri-anim®

License Authorization Form

A CUSTOMER AND SHIPPING INFORMATION

Facility Name:_____ **Account #**_____

Contact Name:_____ **E-mail address:**_____

Company Shipping Address: _____

City: _____ **State:** _____ **Zip:** _____ **Telephone:** _____

B ITEM CERTIFICATION

☐ **We certify that the items purchased** will be used only by the organization named above. The material will not be sold to a third party, distributed or used for any other purpose. Prescription drugs are subject to the U.S. Federal Export Control Regulations and may not be exported or otherwise removed from the U.S. without prior written authorization from the U.S. Department of State. [Please check box]

C PRODUCT CATEGORY AND LICENSE INFORMATION

I, the undersigned, am the Medical Director or Pharmacist-in-Charge for the above-named facility at the above-specified shipping address. In this capacity, I hereby authorize the facility to authorize the below-indicated category(ies) of products and submit the following referenced license(s) with respect to such orders, with a copy of such license(s) attached to this form. [Please check appropriate box(es) and complete corresponding license information.]

☐ I wish to order Unlimited Prescription Drugs and/or Medical Devices or

☐ I wish to order Limited Prescription Drugs and/or Medical Devices, please list:

_____

Physician's License or State Board of Pharmacy License #_____ **Expiration Date:** _____

☐ I wish to order Controlled Substances: License(s) authorizing these items is as follows:

DEA License #_____ **Expiration Date:** _____

If you plan to purchase controlled substances, please have your Medical Director complete our DEA required Controlled Substance Survey in order to give us a baseline of your anticipated controlled substance usage. DEA license must be specific to shipping address. Please provide either medical director, pharmacists-in-charge or entity DEA license that corresponds to desired shipping location. Regardless of shipping address specified in Part A, controlled substances will ship to address corresponding to DEA license provided.

State Controlled Substance License #_____ **Expiration Date:** _____

State controlled substance license is required for certain states. For those states, both the DEA and state license must be provided.

D STATEMENT OF AUTHORITY AND SIGNATURE

I hereby swear under penalty of perjury that (i) I am the (check one): ☐ **Medical Director** ☐ **Pharmacist-in-Charge with responsibility for the facility identified above in Part A with respect to the specified address; (ii) that the license information provided is current and accurate and I am, therefore, licensed to authorize shipment of the substances indicated on this form to the facility designated.**

Signature: _____ **Date:** _____

Print Name: _____ **Print Title:** _____

Medical Director's Email: _____ **Medical Director's Phone:** _____

Instructions:

This Authorization is only valid if accompanied by a copy of the license specified in Part C. This Authorization will expire at the time of the expiration of the above-specified license (as applicable to the product ordered). Upon expiration, a new Authorization must be submitted for orders to be processed. If there is a change in Medical Director or Pharmacist-in-Charge, this Authorization will immediately become invalid and a new Authorization, including applicable license(s), must be submitted for orders to be processed.

Please complete this form and submit a copy of the appropriate license(s) to Customer Licensing by fax to 800-309-6436, by email to custlicense@sarnova.com, or by mail to P.O. Box 8023, Dublin, OH 43016-2023.