



APPLICATION FOR MEMBERSHIP

I. PHARMACY INFORMATION

- A.** Name of Facility: _____
Street Address: _____
P.O. Box: _____
City: _____ State: _____ Zip: _____
Telephone: _____
Fax phone: _____ E-mail: _____
Contact Person: _____ Title: _____
Purchasing Agent: _____
- B.** This pharmacy is
 a stand alone IV Homecare Pharmacy (closed-door - no retail activity).
 within a retail Pharmacy.
 within an Institutional Pharmacy (closed-door, long term care).
 within an Institutional Pharmacy (acute care).
- C.** Number of certified hoods and their classification status: _____

II. PRIMARY SERVICES PERFORMED, PRODUCTS SUPPLIED FOR PATIENTS

- | Please check appropriate area: | Average number of patients/month |
|--|----------------------------------|
| <input type="checkbox"/> Oral Pharmaceuticals to nursing home patients | _____ |
| <input type="checkbox"/> Oral Pharmaceuticals to home care patients | _____ |
| <input type="checkbox"/> IV Antibiotics | _____ |
| <input type="checkbox"/> IV Chemotherapy | _____ |
| <input type="checkbox"/> IV Hydration | _____ |
| <input type="checkbox"/> IV Pain Management | _____ |
| <input type="checkbox"/> IV TPN | _____ |
| <input type="checkbox"/> PCA | _____ |
| <input type="checkbox"/> Medical Supplies | _____ |
| <input type="checkbox"/> Respiratory Supplies | _____ |
| <input type="checkbox"/> Urological Products | _____ |
| <input type="checkbox"/> DME | _____ |
| <input type="checkbox"/> Enteral Tube Feeders | _____ |
| <input type="checkbox"/> Others _____ | _____ |
| Average total number of homecare patients serviced per month: | _____ |
| Average total number of nursing home patients serviced per month: | _____ |

III. LICENSURE

- A. Licensed in state of: _____
- B. Year originally licensed: _____
- C. JCAHO accreditation: _____
- D. D.E.A. number (enclose copy): _____
- E. State License number (enclose copy): _____
- F. Pharmacist in charge: _____

IV. OWNERSHIP

- A. Type of ownership:
- Proprietorship
 - Partnership
 - Corporation (State of incorporation) _____
 - Other (please describe) _____
- B. List all owners/corporate officers. If any owner or officer is also an owner/officer or partner in any other business engaged in the procurement or dispensing of pharmaceuticals, the name(s) and address(es) of such other businesses must be listed. Use extra sheets as necessary.
1. Name _____ Title _____
- Home Address _____
- Home Phone () _____
- Title _____
- Other Business _____
2. Name _____ Title _____
- Home Address _____
- Home Phone () _____
- Title _____
- Other Business _____
3. Name _____ Title _____
- Home Address _____
- Home Phone () _____
- Title _____
- Other Business _____

V. WHOLESALER INFORMATION

- A. Current primary wholesaler
- Name _____
- Address _____
- City _____ State _____ Zip _____
- Telephone _____
- Contact person _____ Title _____

Additional Information: