



## APPLICATION FOR MEMBERSHIP

RxMed will send you a contract for service upon receipt of a completed application. New members are added to the RxMed program on the first of the month thirty days after written notice of membership is sent to the manufacturers and suppliers.

### I. PHARMACY INFORMATION

Name of Pharmacy \_\_\_\_\_  
Street Address \_\_\_\_\_  
P.O. Box \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone number \_\_\_\_\_  
Fax number \_\_\_\_\_  
Contact Person \_\_\_\_\_ Title \_\_\_\_\_  
Purchasing Agent \_\_\_\_\_  
Do you currently or are you considering servicing any Long Term Care facilities? \_\_\_\_\_ Yes \_\_\_\_\_ No

### II. LICENSURE

A. Licensed in state of \_\_\_\_\_ Year originally licensed \_\_\_\_\_  
B. D.E.A. number \_\_\_\_\_  
C. State License number \_\_\_\_\_  
D. Pharmacist in Charge \_\_\_\_\_  
E. NABP number \_\_\_\_\_

### III. WHOLESALE INFORMATION

A. Current primary wholesaler  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone number \_\_\_\_\_  
Contact Person \_\_\_\_\_  
B. Secondary Wholesaler \_\_\_\_\_  
Name \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_

### IV. OTHER BUYING GROUP AFFILIATIONS

\_\_\_\_\_  
\_\_\_\_\_

Please fax or mail to RxMed : 9505 Williamsburg Plaza, Suite 200 ♦ Louisville KY 40222 ♦ Fax (502) 327-9884

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Please  
Place  
Postage  
Here



RxMed<sup>SM</sup>

9505 WILLIAMSBURG PLAZA  
SUITE 200  
LOUISVILLE, KY 40222