

AUTHORIZATION TO PURCHASE

Date: _____ What line of Credit do you request? _____
 Account Number: _____

<p>Shipping Information</p> <p>Business Name: _____</p> <p>Address: _____</p> <p>City: _____</p> <p>State: _____ Zip: _____</p> <p>Phone #: _____</p> <p>Fax #: _____</p> <p>E-mail: _____</p> <p>Name of Contact Person: _____</p> <p>DEA # _____</p> <p>** (please attach a copy of DEA license) **</p>

<p>Billing Information</p> <p>Business Legal Name: _____</p> <p>Address: _____</p> <p>City: _____</p> <p>State: _____ Zip: _____</p> <p>Business #: _____</p> <p>Business Fax #: _____</p> <p>Business E-mail: _____</p> <p>Name of Contact Person: _____</p> <p>Contact Person Phone #: _____</p>

Taxation Exempt : Yes No

****Please attach a copy of your Tax Exemption Certificate ****

- ◆ Local Municipalities in CA and NC are not exempt
 - ◆ Public Schools through High School are taxable in CA and NC
 - ◆ Universities and State Institutions in NC will need the "State Agency" exemption to be tax exempt
- **This Section must be signed – Standard Terms are Net 30 Days ****

Signature: _____

<i>Authorizing Purchasing Agent</i>	<i>Title</i>	<i>Date</i>
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The Applicant warrants the information supplied above to be true, and agrees that information set forth on this form may be shared with affiliates of SHS, Select Health Services, LLC. The Applicant authorizes SHS, Select Health Services, LLC to investigate the references herein, statements or other data obtained from Applicant or from any other person pertaining to the Applicant's credit and financial responsibility.

The Applicant agrees to abide by the Standard Terms of Sale published regularly by SHS, Select Health Services, LLC as shown on SHS, Select Health Services' invoices, or by any other terms of sale upon which SHS, Select Health Services, LLC and the Applicant should agree in writing. The Applicant agrees to pay interest on past due accounts at the highest rate permitted by law, together with attorneys' fees and all other costs and expenses incurred by SHS, Select Health Services, LLC, in collecting such accounts. The Applicant agrees that all payments to which SHS, Select Health Services, LLC is entitled shall be paid to SHS, Select Health Services, LLC.

NOTICE: The federal Equal Credit Opportunity Act prohibits creditors from discriminating against credit applicants on the basis of race, color, religion, national origin, sex, marital status, age (provided the applicant has the capacity to enter into a binding contract); because all or part of the applicant's income derives from any public assistance program; or because the applicant has in good faith exercised any right under the Consumer Credit Protection Act. The federal agency that administers compliance with this law concerning this credit is the Federal Trade Commission, Division of Credit Practices, 6th and Pennsylvania Avenue, NW, Washington, D.C. 20580.

FAX OFFERS: In order for SHS, Select Health Services, LLC to send you money-saving offers and view medical products information via FAX, we need your authorization. By signing below (actual signature required), you consent for your organization to receive fax communications from SHS, Select Health Services, LLC.

Signature: _____ Date: _____

Print Name : _____ Title: _____

Please fax all Medical License(s) to: (504) 737-4500 / (877) 737-6111
 Please fax all other forms to: (504) 737-4500 / (877) 737-6111
 Or mail completed form to: SHS, Select Health Services, LLC, 560 People's Plaza, Box 193, Newark, DE 19702

Phone: (504) 737-43001 / (877) 737-6111