

THIS FORM MUST BE COPIED ON FACILITY LETTERHEAD
MEDASSETS® SUPPLY CHAIN SYSTEMS, LLC GROUP PROGRAM DESIGNATION FORM

To: Vendors/Manufacturers/Distributors

From: MedAssets Supply Chain Systems, LLC Member

This document serves as written confirmation of a primary group purchasing relationship between MedAssets Supply Chain Systems, LLC ("MedAssets") and the customer named below. Any and all previous correspondence regarding this customer is superseded by this declaration.

Customer acknowledges that all purchases made through MedAssets' agreements are for "Own Use" as provided in the Robinson Patman Act and the Supreme Court's ruling in Abbott Laboratories vs. Portland Retail Druggist Association, Inc.

MedAssets Member _____

Address _____

City/State/Zip _____

Telephone Number _____

Fax Number _____

DEA Number _____

HIN Number _____

Class of Trade _____

Facility Type _____

Primary MS Dist. _____

Location (City/State) _____

Secondary MS Dist. _____

Location (City/State) _____

Primary Wholesaler _____

Location (City/State) _____

Primary LAB Dist. _____

Location (City/State) _____

Primary F&N Dist. _____

Location (City/State) _____

Blood Fractions Dist. _____

Location (City/State) _____

This is to advise that we, the above-named MedAssets member, desire to participate in the MedAssets program(s) indicated below, on the effective date noted:

Materials Management Program

The Pharmacy Program

Laboratory Program

DEA Number _____

Food and Nutrition Program

You must attach a copy of the DEA Certificate

Effective Date _____

(To be completed by Membership Coordinator)

Authorized Signature _____

Print Name and Title _____ Date _____

Our participation in the MedAssets above-designated program(s) is with the understanding that you will remove our facility's name from our former designated group contract, indicated below:

Former Group Name _____

Comments regarding this designation _____