NPC
National Physician Care, Inc.

GROUP PURCHASING PROGRAM MEMBERSHIP AGREEMENT

As an authorized agent for: _____ , _____,
Name of Practice *Entity (PC, PA, LLC, etc.)*

I, _____ , _____ hereby authorize and appoint
Print Your Name *Title*

National Physician Care, Inc. (NPC) as our group-purchasing agent for the purpose of recommending and endorsing goods and services for our use as long as this Group Purchasing Program Membership Agreement remains in effect.

AS A MEMBER OF NPC, I AGREE TO KEEP ALL PRICING AND CONTRACT INFORMATION CONFIDENTIAL.

I recognize that the purchasing programs offered by NPC may include an administrative fee paid by the contracted vendors to NPC. Such compensation may be a fixed amount or a percentage of the value of purchases made by your Practice from a vendor, but in no case shall it exceed three percent (3%) without appropriate notification to your Medical Practice.

Furthermore, I understand that some contracted vendors may impose purchasing requirements as a condition of participation in their respective discount program(s). Membership in NPC does not automatically provide access to NPC's vendor contracts. I agree to review each vendor's Contract Designation Form that I intend to use and abide by any conditions contained therein.

NPC represents and warrants that its Group Purchasing Program and related activities comply with applicable state and Federal laws, including the relevant provisions of the Federal "Safe Harbor" regulations found at 42 CFR 1001. Your Medical Practice, by executing this Agreement, agrees to disclose and appropriately reflect any discount or reduction in price received in any cost report submitted to any governmental programs, including but not limited to, the Medicare and Medicaid programs.

This Group Purchasing Program Membership Agreement shall remain in effect for one year from the date of signature unless terminated by either party upon thirty (30) days advance written notice. Unless otherwise notified, this agreement shall renew for additional one-year periods on the anniversary date each year hereafter.

PLEASE COMPLETE THE FOLLOWING INFORMATION

Name of Practice: _____

DEA # for your main office: _____ (Will be your NPC Account #)

Primary Office Address: _____

Suite#: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

Managing Physician: _____ , _____ MD _____ DO

Email: _____

Practice Manager: _____ Title: _____

Email: _____

Type of Practice: Pediatric ____ Family Practice ____ Internal Med ____ Travel Med ____ Other _____

# of Office Locations: _____ # of Providers: Physicians _____ NP _____ PA _____

Authorized Signature: _____ Date: _____

Print Name: _____ Title: _____