ProviderSelect:*MD*

PREMIER

COASTAL PHYSICIANS PURCHASING GROUP

Membership Application Form – Provider Select: *MD*

This Letter of Participation is entered into by the undersigned Candidate effective as of the date of acceptance by Provider Select, LLC ("Provider Select") as set forth below and is comprised of this cover sheet and the attached terms and conditions. ***(* Required Fields)***

Candidate Information: (*Please provide all bill to and ship to address information on page 3.)*

Candidate Name: *	Primary Contact Name: *
Street Address *(No P.O. Boxes please.)*: *	Primary Contact Title: *
City: *	Primary Contact Phone Number: *
State and Zip: *	Primary Contact Fax Number: *
DEA #:	Primary Contact Email: *

Proprietor Information (holder of legal or equitable title)

This facility is Owned by:	Confidentiality Request: Would you like Premier to keep confidential the name of the Owners: ☐ Yes ☐ No

Sponsor Information:

Sponsor Name: Coastal Physicians Purchasing Group	Sponsor City and State: Newport Beach, CA
Sponsor Entity Code: 645229	

Physician Practice / Medical Group Specialty* (check all that apply)			
☐ Allergy & Immunology	☐ Gastroenterology	☐ Oncology	☐ Podiatry
☐ Cardiovascular Disease	☐ Family Practice	☐ Ophthalmology	☐ Psychiatry
☐ Dentistry	☐ Infertility	☐ Orthopedics	☐ Pulmonology
☐ Dermatology	☐ Internal Medicine	☐ Otolaryngology	☐ Rehabilitation
☐ Ear, Nose & Throat	☐ Neurology	☐ Pain Management	☐ Surgery
☐ Emergency Medicine	☐ OB/GYN	☐ Pediatrics	☐ Urology
☐ Endocrinology	☐ Occupational Medicine	☐ Plastic Surgery	☐ Other

I understand that Provider Select may share information with vendors, sponsors and other third parties.
For some programs and contracts, completion of specific participation forms may be required prior to obtaining contract pricing. Please contact Premier's Solution Center at (877) 777-1552 for more details.

For Premier Internal Use Only:	**For McKesson Internal Use Only:**
Verified By:_______________	McKesson Rep:_______________
Entity Code: _______________	Legacy McKesson ID w/ Ship to:_______________

Return the completed application via fax to 949/764-1496.

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ProviderSelect:MD

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TERMS AND CONDITIONS

1. Candidate agrees to use the program materials provided to Candidate by Provider Select and any affiliate of Provider Select ("Program Materials") only in connection with Candidate's participation in Provider Select group purchasing programs. Candidate agrees that title to and ownership of the Program Materials shall remain with Provider Select and/or any such affiliate. Candidate will maintain the confidentiality of Program Materials and all information contained therein, and will not disclose same to any third parties. Candidate will return all Program Materials to Provider Select upon the termination of Candidate's participation in Provider Select group purchasing programs.
2. The Provider Select medical/surgical group purchasing program contemplates as a goal that Candidate will purchase eighty percent (80%) (by annual dollar volume) of its annual requirements for all medical/surgical products and supplies covered under the program from the Provider Select distributor.
3. If Candidate participates in the Provider Select Pharmacy Purchasing program, Candidate is required to select pharmacy participation and abide by the terms and conditions contained in this document below.
    a. Candidate agrees to purchase all of its annual requirements for pharmaceutical products which are covered by contract awards made by the Pharmacy Program through Purchasing Partners group agreements.
    b. Participation in the Pharmacy Program precludes membership in other national group purchasing organizations' pharmacy programs. Candidate hereby designates Purchasing Partners as Candidate's sole purchasing agent for pharmaceutical products and agrees to purchase Candidate's requirements for pharmaceutical products through the Pharmacy Program.
    c. Candidate acknowledges that by selecting pharmacy participation and complying with the terms and conditions of participation, it is entitled to purchase drugs under the contract awards made by the Pharmacy Program.
    d. Candidate agrees and acknowledges that the Pharmacy Program is its sole national group purchasing program. So that the contracted manufacturers and suppliers can keep their records up to date and to assure that you receive correct pricing, please indicate the group or groups that you are leaving:

       ____
    e. Candidate understands that each manufacturer agreement has individual terms and conditions.
4. Candidate hereby designates Provider Select to act as Candidate's purchasing agent for any and all medical, surgical, pharmacy (if Candidate participates in the pharmacy program) and other products purchased by Candidate through Provider Select group purchasing programs. Candidate understands that Provider Select will act as candidate's primary group purchasing organization. If the pharmacy program is selected, Provider Select will be the exclusive group purchasing program used by Candidate for the products within that portfolio.
5. Provider Select hereby discloses to Candidate that, in consideration for administrative services, Provider Select or Premier Purchasing Partners, L.P. ("Purchasing Partners"), will be paid an administrative fee by contracted manufacturers and suppliers in an amount not to exceed three percent (3%) of the purchase price of aggregate purchases by Candidate except as set forth in an Administrative Fee Exception Schedule that will be provided to Candidate in the event of any exceptions. The Schedule will be updated from time to time as necessary and such updates will be deemed to be incorporated in this Letter of Participation immediately upon transmission to Candidate. Provider Select will also disclose annually to Candidate the amount of any such fees earned by Provider Select or Purchasing Partners, by vendor, with respect to purchases made by or on behalf of Candidate.
6. Candidate acknowledges and agrees that any action by Candidate which is inconsistent with the terms hereof may result in the termination by Provider Select, at Provider Select's sole discretion, of Candidate's participation in any or all Provider Select group purchasing programs. By signing this Letter of Participation, Candidate acknowledges its intent to: (i) participate in Provider Select group purchasing programs and (ii) comply with the participation requirements described herein.
7. This Letter of Participation may be canceled by either Provider Select or Candidate by giving at least thirty (30) days written notice of cancellation to the other.
8. This Letter of Participation represents the entire agreement between Provider Select and Candidate regarding Provider Select participation requirements and supersedes any prior oral or written agreement concerning such subject matter.
9. Candidate represents that all products purchased under Provider Select and/or Purchasing Partners negotiated agreements are for its own operations, excluding operations which compete with retail trade, and are not for resale.
10. During the term of this agreement, Candidate agrees to require individuals (employees, agents, designated representatives) made aware of confidential information to keep confidential and not disclose to any third parties other than Provider Select and Purchasing Partners or other employees of Candidate with a need to know (who have been made aware of this provision by the Candidate) any information designated as confidential by Provider Select or Purchasing Partners by either oral or written statement without Provider Select's and/or Purchasing Partners' prior written permission. Such confidential information may take many forms, but is likely to include Provider Select's and/or Purchasing Partners' plans, reports, proposals, agreements, organizational documents, clinical studies, software, pricing information, and contract catalogs (printed and electronic).
11. Candidate agrees during the term of this Letter of Participation not to use any Provider Select or Purchasing Partners agreements as leverage to negotiate individual or system agreements with Provider Select's or Purchasing Partners' contracted vendors or other competing vendors.
12. For Provider Select: MD Physician Office Candidates, McKesson is the sole distributor for products purchased through group agreements. Candidate further authorizes McKesson to release total purchase data (in the ANSI 867 X12 EDI Format) to Provider Select and Purchasing Partners on a monthly basis.
13. Candidate acknowledges that in order to access this program, McKesson may require the completion of its participation document.
    This agreement is subject to Premier's Group Purchasing Code of Conduct which can be accessed at http://www.premierinc.com/all/ethics-and-compliance/attachments/gps-code-of-conduct-reference-guide.pdf

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Form was completed by:

First and Last Name *(Please Print)*	Date
Signature	Title

Return the completed application via fax to 949/764-1496.

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Multi-site Addendum

All the facilities submitted in the form below are entered in the Letter of Participation and attached terms and conditions as signed by candidate above and effective as of the date of acceptance by Provider Select LLC ("Provider Select"). ***(* Required fields)***

Bill to Address			**Ship to Address**		
Facility Name: *			Facility Name: *		
Street Address:*			Street Address:*		
City:*	State:*	Zip:*	City:*	State:*	Zip:*
DEA #:			DEA #:		
Legacy McKesson ID w /Ship to: (For McKesson Internal Use Only)	-		*Legacy McKesson ID w/ Ship to: (For McKesson Internal Use Only)*	-	

Ship to Address			**Ship to Address**		
Facility Name: *			Facility Name: *		
Street Address:*			Street Address:*		
City:*	State:*	Zip:*	City:*	State:*	Zip:*
DEA #:			DEA #:		
Legacy McKesson ID w /Ship to: (For McKesson Internal Use Only)	-		*Legacy McKesson ID w /Ship to: (For McKesson Internal Use Only)*	-	

Ship to Address			**Ship to Address**		
Facility Name: *			Facility Name: *		
Street Address:*			Street Address:*		
City:*	State:*	Zip:*	City:*	State:*	Zip:*
DEA #:			DEA #:		
Legacy McKesson ID w /Ship to: (For McKesson Internal Use Only)	-		*Legacy McKesson ID w /Ship to: (For McKesson Internal Use Only)*	-	

Ship to Address			**Ship to Address**		
Facility Name: *			Facility Name: *		
Street Address:*			Street Address:*		
City:*	State:*	Zip:*	City:*	State:*	Zip:*
DEA #:			DEA #:		
Legacy McKesson ID w /Ship to: (For McKesson Internal Use Only)	-		*Legacy McKesson ID w /Ship to: (For McKesson Internal Use Only)*	-	

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