

# ProviderSelect: MD™ Membership Application

## Participating Member Information: (Please provide all bill-to and ship-to address information on page 3)

Participating Member Facility/Practice Name:			Primary Contact Name:		
Street Address (No P.O. Boxes please.):		Ste./Fl.:	Primary Contact Title:		
City:	State:	Zip Code:	Primary Contact Phone Number:		
Facility/Practice Phone Number:			Primary Contact Email:		

## Sponsor Information: If there is no sponsor, leave this section blank.

Sponsor Name: IPC Group Purchasing		Direct Parent Name (parent company, if different from Sponsor): CCPA Purchasing Partners, LLC	
Sponsor Entity Code: 636729		Direct Parent Entity Code: 700683	
<b>Participating Member Relation to Direct Parent<sup>1</sup> (If No Direct Parent, Indicate Participating Member Relation to Sponsor):</b> <input type="checkbox"/> Owned <input type="checkbox"/> Leased <input type="checkbox"/> Managed <input checked="" type="checkbox"/> Affiliated (Not Owned, Leased or Managed)			

## Physician Practice / Medical Group Specialty\* (check all that apply)

<input type="checkbox"/> Allergy & Immunology	<input type="checkbox"/> Family Practice	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Rehabilitation
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Infertility	<input type="checkbox"/> Otolaryngology	<input type="checkbox"/> Surgery
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Urgent Care
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Neurology	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Urology
<input type="checkbox"/> Ear, Nose & Throat	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Plastic Surgery	<input type="checkbox"/> Other
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Occupational Medicine	<input type="checkbox"/> Podiatry	
<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Oncology	<input type="checkbox"/> Psychiatry	
<input type="checkbox"/> Gastroenterology	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Pulmonology	

\*Prospective members that are not physician practices/medical groups (such as surgery centers, imaging centers, home health care agencies, clinical labs, long term care facilities and DMEs) must complete a Premier Continuum of Care Membership Application rather than this ProviderSelect: MD application in order to join Premier. Please contact [Rosters@PremierInc.com](mailto:Rosters@PremierInc.com) with questions.

## Pharmacy Program Participation:

A DEA # and/or HIN # must be provided in order to participate in the pharmacy program. The registered address for the DEA and/or HIN must match the address provided above in order to gain access to the program. Some suppliers may require a DEA # (rather than a HIN) in order to provide access to program pricing. DEA and HIN #s for all ship to addresses accessing the program must be provided on Page 3. If Participating Member will not be participating in the pharmacy program, please write "Opt-out" below.

DEA #: \_\_\_\_\_ HIN #: \_\_\_\_\_

### <sup>1</sup>Definitions for the types of member facilities relationships (collectively, the "Child Sites") :

**OWNED:** A facility is considered to be owned if the Sponsor or Parent directly or indirectly holds (1) a majority of the equity or corporate membership interests in the facility or the power to appoint a majority of such facility's governing board or (2) a significant interest (which may be less than a majority of the total equity) sufficient to enable operational control and such facility is willing to designate Premier Healthcare Alliance, L.P. as its primary group purchasing organization.

**LEASED:** A facility is considered to be leased if it is leased and operated by its Sponsor or Parent.

**MANAGED:** A facility is considered to be managed if the Sponsor or Parent manages such facility in whole or in part (including at a minimum, the supplies purchasing function).

**AFFILIATED:** A facility is considered to be affiliated if the Sponsor or Parent formally sponsors the facility for participation in Premier's group purchasing organization, but does not own, lease or manage it.

## To Be Completed by McKesson Account Manager:

McKesson Account Manager Name:	Account Manager Phone Number:	Account Manager Email Address:
Account Number:		

**TERMS CONDITIONS AND SIGNATURES (the "Agreement")**

By signing below, Participating Member agrees that:

- A. The ProviderSelect: MD medical/surgical group purchasing program ("ProviderSelect: MD Program") contemplates as a goal that Participating Member will purchase at least eighty percent (80%) (by annual dollar volume) of its annual requirements for all medical/surgical products and supplies covered under the ProviderSelect: MD Program from the ProviderSelect: MD distributor. Participating Member further authorizes the ProviderSelect: MD distributor to release all of Participating Member's purchase data to Premier Healthcare Alliance, L.P. ("Premier").
- B. Participating Member hereby designates Premier to act as Participating Member's group purchasing agent for the products and services (collectively, "Products") purchased by Participating Member through the ProviderSelect: MD Program.
- C. Participating Member will use Premier as its primary group purchasing organization.
- D. Participating Member will use all Products it purchases under group purchasing agreements of Premier and, if applicable, the sponsor named on the first page of this Agreement ("Sponsor") solely for its own operations and will not re-sell any such Products.
- E. Participating Member (and Participating Member's agents, employees and representatives) shall keep confidential Premier's and Sponsor's proprietary and confidential information and shall not disclose such information to any third parties other than Premier's affiliates, Sponsor or Participating Member's employees with a need to know (who have been made aware of this provision by Participating Member and agree to comply with it). Such confidential information includes without limitation Premier's and Sponsor's plans, reports, proposals, agreements, organizational documents, clinical studies, software, pricing information, and contract catalogs (printed and electronic). Participating Member's obligation to maintain the confidentiality of such information shall remain in effect continuously throughout the period of Participating Member's membership in Premier and for a period of five (5) years thereafter.
- F. In the event Participating Member is subject to applicable open records laws (such as a federal, state or municipal agency) which may require Participating Member to release confidential or proprietary information of Premier or Sponsor, Participating Member agrees to promptly notify Premier and/or Sponsor, as applicable, of any request under such laws for the release of such information. Further, Participating Member shall cooperate in good faith with Premier and Sponsor and use its best efforts to assist Premier and Sponsor in preventing the release of such information to the extent consistent with applicable law.
- G. Participating Member represents and warrants that it (and its officers, directors and employees) are not listed by a federal or state agency as excluded, debarred, suspended or otherwise ineligible to participate in any federal and/or state programs. Premier and/or Sponsor may terminate Participating Member from participation in the ProviderSelect: MD Program immediately in the event at any point Participating Member is not in compliance with this representation and warranty. Termination is in addition to any other rights or remedies Premier and Sponsor may have at law or in equity.
- H. Participating Member acknowledges that rebates or discounts it may receive from ProviderSelect: MD vendors ("Vendors" or each a "Vendor") as part of its participation in the ProviderSelect: MD Program are, for purposes of 42 C.F.R. Section 1001.952(h), "discounts or other reductions in price" and Participating Member is required to disclose the specified dollar value of any such discounts or reductions in price under any state or federal program which provides cost or charge-based reimbursement to such Participating Members.
- I. Participating Member acknowledges and agrees that by entering into this Agreement the parties have not established, and do not intend to establish, a "business associate" relationship, as such term is defined under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 ("HIPAA"). Under no circumstances will Premier request from Participating Member, nor will Participating Member provide to Premier, "protected health information," as such term is defined in HIPAA. For the avoidance of doubt, Participating Member agrees that Premier is not engaging any Vendor as its downstream business associate.
- J. Participating Member represents and warrants that its execution and performance of this Agreement does not conflict with or violate any other agreement or obligation to which Participating Member is subject or by which it is bound.
- K. Participating Member acknowledges and agrees that Premier, its affiliates and their respective directors, officers, employees and agents will not be liable for the acts or omissions of Premier's contracted suppliers, or for any representations or warranties made by such suppliers.
- L. Participating Member confirms that all information supplied by Participating Member to Premier and Sponsor is complete and accurate.
- M. Participating Member authorizes Premier and Sponsor to individually activate group purchasing contracts on its behalf.
- N. Participating Member agrees during the term of this Agreement not to use any Premier agreements as leverage to negotiate individual or system agreements with Premier's contracted Vendors or other competing vendors that exclude Premier.
- O. Premier shall have the right in its sole and absolute discretion to immediately terminate or deny the membership of Participating Member or any Child Site or organization (i) in the event Participating Member or such Child Site or organization acts in a manner that is inconsistent with the ProviderSelect: MD Program's spirit of intent or violates the participation requirements of the ProviderSelect: MD Program; or (ii) whose involvement with Premier has the potential to damage the reputation of Premier and/or any of its affiliated companies. Notwithstanding anything to the contrary, Participating Member's membership shall automatically terminate if Participating Member becomes a contracted supplier of Products under the ProviderSelect: MD Program.
- P. Premier and Sponsor, if applicable, are each authorized to act as a purchasing agent for Participating Member and any Child Sites that are added to Schedule 1 as it may be amended from time to time.
- Q. Participating Member is hereby notified that Vendors pay to Premier an administrative fee, which is a percentage of the purchase price of Products that Participating Member purchases from such Vendors, which may be apportioned between Premier and Sponsor pursuant to a separate agreement. Administrative fees will be noted in a report located in Premier's online member portal.
- R. Except as otherwise directed, Premier shall provide written notice at least annually to Participating Members that are healthcare providers of service<sup>1</sup>, of the amount of administrative fees that Premier has received from Vendors with respect to purchases made by or on behalf of such Participating Member.
- S. If Participating Member participates in Premier's Pharmacy program, the following additional terms apply:
  - 1. Participating Member hereby designates and will use Premier's Pharmacy Program as its Primary GPO for Participating Member and all Child Sites currently owned or subsequently acquired by Participating Member or any affiliate of Participating Member.
  - 2. Participating Member designates the Pharmacy Program's authorized pharmacy wholesaler (the "Authorized Wholesaler") as its prime Vendor for purchasing pharmaceuticals under the Pharmacy Program. Participating Member further authorizes the Authorized Wholesaler to release total purchase data to Premier.
  - 3. Participating Member understands that each Vendor and each wholesaler contract in the ProviderSelect: MD Program has individual terms and conditions.
- T. If Participating Member is a Multi-Facility System, Participating Member will list on Schedule 1 attached to this Agreement the facilities that it intends to serve as Child Sites subject to the terms of this Agreement. Participating Member may update the Child Site list upon written notice to Premier consistent with the terms of this Agreement. Participating Member represents that it has authority over all purchases, including liability for payment of invoices, for each Child Site listed and that it has the authority to sign and bind each Child Site to the terms of this Agreement. In such case, Participating Member and each such Child Site shall be bound by the terms of this Agreement.
- U. In addition to compliance with the terms and conditions contained in this Agreement, Participating Member shall comply with all Premier policies pertinent to the Program.
- V. Participating Member will receive any applicable Vendor rebates that are earned from purchases through the Premier Program via Electronic Funds Transfer (EFT). Please complete the Direct Deposit Via ACH Form and IRS Form W-9.

\_\_\_\_\_  
Signature of Participating Member

\_\_\_\_\_  
Printed Name of Participating Member

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date



\_\_\_\_\_  
Signature of Sponsor

**Sonia Gandara**  
Printed Name of Sponsor

**Member Relations Specialist**  
Title

\_\_\_\_\_  
Date

<sup>1</sup> As defined in Section 1861(u) of the Social Security Act.

## Schedule 1 – Child Site List

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Please use the form attached below to list all Child Sites that will be receiving Products through the Premier Program that meet the following requirements below:

1. **The Participating Member has legal authority to sign and bind the Child Site to Program contracts, including the terms of this Agreement.**
2. **The Participating Member has control over all supply chain and purchased services for the Child Site.**

If either of the requirements above are not met, the Child Site must complete its own, separate Membership Application.

By submitting Schedule 1 to Premier, Participating Member certifies that the responses listed on Schedule 1 are true and accurate.

Participating Member authorizes and designates its Sponsor, distributor/wholesaler or other agent to add new Child Sites by submitting to Premier a list of new Child Sites on the attached form or by other written communication for the same purpose. Participating Member acknowledges and agrees that by making or authorizing any such future submissions of Child Site(s), unless expressly stated otherwise in the applicable submission, Participating Member certifies that it (1) has legal authority to sign and bind the Child Site(s) to contracts, including the terms of this Agreement, and (2) has control over all supply chain and purchased services for the Child Site(s).

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*\* A DEA # and/or HIN # must be provided for all Child Sites that will be participating in the Premier ProviderSelect: MD Program. The registered address for the DEA and/or HIN must match the address associated with it on this form in order to gain access to the ProviderSelect: MD Program. Some Vendors may require a DEA # (rather than a HIN) in order to provide access to ProviderSelect: MD Program pricing.*

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Exh D - Sch 1 List of  
Child Sites\_11-10-23.x

Email the completed Agreement to [Rosters@PremierInc.com](mailto:Rosters@PremierInc.com).

**COMPLETION OF THIS APPLICATION DOES NOT GUARANTEE ACCEPTANCE BY PREMIER.**

EXHIBIT F

**DESIGNATION FORM**

This Designation Form ("**Designation Form**") is entered into as of the date of Participant's signature below, by and between the Participant identified in the signature line below ("**Participant**"), and the Distributor(s) indicated below ("**Distributor**"). By signing this Designation Form, Participant agrees to be bound by the terms and conditions negotiated on its behalf by **CCPA PURCHASING PARTNERS, L.P. ("Group")** in that certain Group Purchasing Agreement ("**Group Purchasing Agreement**"), a copy of which can be obtained from Group.

1. **Group Designation.** Participant designates Premier, Inc. as its primary purchasing group affiliation for the purpose of this Designation Form.
2. **Distributor Designation.** Participant designates McKesson Medical-Surgical Inc. as Prime Distributor for the purpose of this Designation Form.
3. **Purchase Commitment.** Participant appoints Distributor as its distributor for medical-surgical products and commits to purchase annually at least ninety (90%) of its requirements for such medical-surgical products available for sale from Distributor.
4. **Term.** The term of this Designation Form will be concurrent with the term of the Group Purchasing Agreement, unless sooner terminated by the parties hereto.
5. **Termination.** This Agreement may be terminated prior to expiration only as follows:
  - 5.1. Termination for Breach. In the event of breach of any provision of this Designation Form, the non-breaching party will notify the breaching party in writing of the specific nature of the breach and will request that it be cured. If the breaching party does not cure the breach within thirty (30) days of receipt of such notice, the non-breaching party may immediately terminate this Designation Form on written notice to the other party, and such termination will not preclude the non-breaching party from pursuing any and all remedies available to it at law or in equity.
  - 5.2. Termination Due to Change in Control. Distributor may, at its own discretion, terminate this Designation Form upon ten (10) days written notice to Participant upon or at any time following the sale or transfer of the stock or assets of Participant or a controlling interest therein, or a change in the effective control of the management of Participant.
  - 5.3. Termination Without Cause. Either party may terminate this Agreement at any time without cause or penalty upon providing the other party with ninety (90) days' advance written notice.
6. **Continuing Obligations.** In the event of a termination or expiration hereunder of this Designation Form:
  - 6.1. Obligations Incurred Prior to Termination. The liability of Participant for obligations incurred prior to the effective termination date, for finance charges and for all costs of collection, including reasonable attorneys' fees, will survive termination; and
  - 6.2. Obligation for Additional Products. In the event of any termination or expiration of this Designation Form by either party, regardless of the reason for such termination or expiration (or upon request by Distributor in the event of Slow Moving Inventory), a Participant will purchase at least thirty (30) days prior to the expiration date or the end of the term of this Designation Form: (i) any and all Custom Products on order with Distributor, in transit to such Participant, or held in inventory by Distributor for such Participant; (ii) any other Products not described in Subsection (i) above ("**Additional Products**") in transit or held in inventory by Distributor for such Participant; and (iii) any Custom Products and/or Additional Products that are Slow Moving Inventory. A Participant will not be required under Subsection (ii) or Subsection (iii) above to purchase a quantity of Additional Products that exceeds sixty (60) days of inventory,

determined by multiplying sixty (60) by such Participant’s average daily purchases of Additional Products by such Participant during the six (6) month period immediately prior to the date of such termination or expiration.

6.3. Orders Placed Prior to Termination. Distributor will fulfill, in accordance with the terms of this Designation Form, all orders for Products and Services submitted by a Participant and received by Distributor prior to termination or expiration of this Designation Form.

7. **Confidential Information.**

7.1. Confidentiality. Notwithstanding anything in this Designation Form to the contrary, the Pricing and terms of this Designation Form will be proprietary and confidential to Distributor, Participant will not disclose such Pricing and terms without prior written consent from Distributor.

7.2. Return of Confidential Information. The Recipient will return to the Discloser, and destroy or erase all of the Discloser’s Confidential Information in tangible form, upon the expiration or termination of this Designation Form, and the Recipient will promptly certify in writing to the Discloser that it has done so. The Recipient may retain one (1) copy of Confidential Information for its legal archives, provided that such Confidential Information will remain subject to the provisions of this Designation Form unless and until the Confidential Information is returned to the Discloser. For purposes of this Designation Form: (a) the “Recipient” means the party receiving the Confidential information from the Discloser; (b) the “Discloser” means the party disclosing the Confidential information to the Recipient; and (c) “Confidential Information” means non-public information relating to the Discloser’s business, including technical, marketing, financial, personnel, planning, medical records and other information that is marked confidential or which the Recipient should reasonably know to be confidential given the nature of the information and the circumstance of disclosure, including the information set forth in the Section above. Notwithstanding the foregoing, Participant acknowledges that Distributor will use and provide information: (i) for internal purposes; (ii) to the extent reasonably necessary to fulfill our obligations under this Designation Form (including without limitation substantiation of claims for Chargebacks or rebates); (iii) to third party data organizations or Suppliers; (iv) as required by law or governmental authorities or in response to subpoenas; or (v) in a de-identified, aggregated manner.

The undersigned Participant hereby acknowledges and confirms the above designations.

**PARTICIPANT**

Print Name of Person Signing \_\_\_\_\_

Signature \_\_\_\_\_

Title of Person Signing \_\_\_\_\_

Date Signed \_\_\_\_\_

Print Name of Participant \_\_\_\_\_

Street Address \_\_\_\_\_

City, State Zip \_\_\_\_\_

**Upon completion, submit this Designation Form to your Distributor Account Manager.**

**Please also submit this page along with page 47 to CCPA Purchasing Partners:**

**Fax: 888.276.2344**

**Email: [applications@ccpapp.org](mailto:applications@ccpapp.org)**

# LETTER OF GPO DESIGNATION

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(Month day, year)

Re: Primary GPO Designation

Dear BD ("Vendor"):

Please be advised that effective as of \_\_\_\_\_ (date), \_\_\_\_\_ (name of Healthcare Organization) ("Customer"), on behalf of itself and all facilities and/or affiliates set forth on the attached Exhibit 1, hereby designates Premier Healthcare Alliance, L.P., f/k/a Premier Purchasing Partners, L.P. ("Premier") ("Designated GPO"), as its group purchasing organization for the purchases of products from BD and its subsidiaries (ex. CareFusion) and affiliates pursuant to the terms of the existing agreements between Designated GPO and Vendor. Customer hereby acknowledges that (a) it is aware of Vendor's single GPO Designation policy and therefore will be connected to, and only to, the contract portfolio of its Designated GPO for Vendor's entire product portfolio; and (b) facilities on Exhibit 1 may be added or deleted only upon the mutual written agreement of Customer and Vendor, and may impact previously set commitment levels on a go-forward basis.

The designation in this letter supersedes any other group purchasing organization designation that Vendor may have on file. Vendor will rely on this designation unless it is revoked in writing by Customer.

If you have questions, please do not hesitate to contact \_\_\_\_\_ (Healthcare Organization point of contact) at \_\_\_\_\_ phone/email or **Paresh Patel: 312-227-7436** (GPO point of contact phone/email).

Name

Title

Healthcare Organization Name

Street

City, St, ZIP

Phone

Email

SIGNATURE:

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# LETTER OF GPO DESIGNATION

## EXHIBIT 1

**(Healthcare Organization Name) Facilities Listing**