CCPA Purchasing Partners, LLC
225 E. Chicago Avenue, Box 113
Chicago, Illinois 60611-2605
Phone: 312.227.7444
Fax: 888.276.2344
www.ccpapp.org

CCPA Purchasing Partners, LLC
Member Information Form

PLEASE COMPLETE AND SUBMIT THIS FORM ALONG WITH CCPA PURCHASING PARTNER'S GROUP PURCHASING PARTICIPATION AGREEMENT

(To complete this form and the Group Purchasing Participation Agreement online, visit www.ccpapp.org and click "Join")

Note: As outlined in CCPA Purchasing Partners' *Group Purchasing Participation Agreement*, members are eligible to receive an annual administrative award distribution. Practices may elect not to receive their annual distributions by notifying CCPAPP in writing. Please email info@ccpapp.org and include your practice name, Tax ID Number, and phone number. You may also submit CCPAPP's *Distribution Declination Form* found on our website: www.ccpapp.org/members/ccpapp-business/

(1) PRACTICE INFORMATION AND PRIMARY ADDRESS:

Practice Name: _____

Practice Tax Identification Number: _____

Practice Type (please check one):

☐ Individual/Sole Proprietor ☐ S-Corporation ☐ C-Corporation ☐ Single-Member LLC ☐ Multi-Member LLC ☐ Partnership

Practice Address: _____ Suite Number: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Primary Contact/Office Manager (Name & Title) _____

Practice Website (if available) _____

Primary Practice Email* (REQUIRED): _____

(2) ADDITIONAL PRACTICE ADDRESS (ATTACH ADDITIONAL SHEETS IF NECESSARY):

Practice Address: _____ Suite Number: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Additional Email* (OPTIONAL): _____

(3) WHICH VENDOR PARTNERS ARE YOU INTERESTED IN? (Please check all that apply)

❒ **Merck** *(vaccines)*
❒ **Sanofi Pasteur** *(vaccines including Flu)*
❒ **Astrazeneca** *(Flumist vaccine)*
❒ **Pfizer** *(Trumenba Vaccine)*

❒ **Access** *(document storage; scanning)*
❒ **COTG** *(office equipment))*
❒ **LB Medwaste Services** *(medical waste disposal)*
❒ **McKesson** *(medical-surgical supplies)*
❒ **Medix** *(temporary staffing)*

❒ **Staples** *(office supplies)*
❒ **Summit Technologies** *(IT support)*
❒ **USPAY** *(electronic payments)*
❒ **Warehouse Direct** *(office supplies)*

❒ **To help ensure that your practice is accurately linked to our discount agreements, CCPAPP may provide your practice name, address, and/or other information listed on this form to our business partners. Please check this box to acknowledge that you are aware that your information may be shared. *Please note: CCPAPP cannot process your application unless this box has been checked.***

(4) HOW DID YOU LEARN ABOUT CCPA PURCHASING PARTNERS? (Please check all that apply)

❒ Website ❒ Another practice/physician ❒ Mailing ❒ Professional Organization/Society: _____

❒ CCPAPP contracted vendor/vaccine company (Please list company and contact if available): _____

❒ CCPA Purchasing Partners' Staff ❒ Other (Please explain) _____

**Please note:* *Your email address is used by CCPA Purchasing Partners only for the purpose of sending out important communications and membership updates. We require that your practice provides CCPAPP with at least one valid email address to ensure that your practice is in receipt of the information. You may also provide additional email addresses to be included in our email distribution. If any of the email addresses provided to CCPAPP are updated, please notify CCPAPP right away.*

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CCPA Purchasing Partners, LLC Member Information Form (continued)

The following is a complete and accurate list of all physicians/providers who are owners or employees of the member practice. Please note that the physician listed first will be considered the primary physician of the practice group. Correspondences sent from CCPA Purchasing Partners to our practice may be delivered to his or her attention. **Please attach additional sheets as necessary**.

(5) PRIMARY PHYSICIAN/PROVIDER INFORMATION: (EMAIL ADDRESS WILL BE USED FOR CCPAPP USAGE ONLY)

Physician Name and Title: _____

Email* (OPTIONAL):_____ Gender: Male____ Female____

Specialty(s)/subspecialty(s): _____DEA License # _____

(6a) ADDITIONAL PHYSICIAN/PROVIDER INFORMATION: (EMAIL ADDRESS WILL BE USED FOR CCPAPP USAGE ONLY)

Physician Name and Title: _____

Email* (OPTIONAL):_____ Gender: Male____ Female____

Specialty(s)/subspecialty(s): _____DEA License # _____

(6b) ADDITIONAL PHYSICIAN/PROVIDER INFORMATION: (EMAIL ADDRESS WILL BE USED FOR CCPAPP USAGE ONLY)

Physician Name and Title: _____

Email* (OPTIONAL):_____ Gender: Male____ Female____

Specialty(s)/subspecialty(s): _____DEA License # _____

(6c) ADDITIONAL PHYSICIAN/PROVIDER INFORMATION: (EMAIL ADDRESS WILL BE USED FOR CCPAPP USAGE ONLY)

Physician Name and Title: _____

Email* (OPTIONAL):_____ Gender: Male____ Female____

Specialty(s)/subspecialty(s): _____DEA License # _____

(6d) ADDITIONAL PHYSICIAN/PROVIDER INFORMATION: (EMAIL ADDRESS WILL BE USED FOR CCPAPP USAGE ONLY)

Physician Name and Title: _____

Email* (OPTIONAL):_____ Gender: Male____ Female____

Specialty(s)/subspecialty(s): _____DEA License # _____

Please attach additional sheets if there are additional physicians/providers at your practice

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This form along with the Group Purchasing Participation Agreement may be faxed, emailed or mailed:

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