EXHIBIT F

MedImmune

GROUP PURCHASING ORGANIZATION DECLARATION FORM

To comply with MedI Biologics, Inc. Single Dedication Policy, please accept this declaration form that:

_____
(Facility Name)

("Facility") is confirming CCPA Purchasing Partners, LP
(Group Purchasing Organization & SubGroup, if applicable)

as the exclusive Group Purchasing Organization ("GPO") for contract eligibility with MedImmune.

This document will serve as written confirmation of the exclusive GPO of choice by Facility, and will remain in effect and on file until further written confirmation of a change has been received and approved by MedImmune. MedImmune, as referred to herein, shall mean MedI Biologics, Inc. (MEDI) for all products identified by a MEDI product code, labeler code, or National Drug Code (NDC) number. The undersigned agrees to permit MedImmune to at least annually audit, on reasonable notice and during normal business hours, the relevant records and books of the undersigned. The undersigned certifies on behalf of Facility that all data submitted by Facility to the exclusive GPO of choice or to MedImmune for chargebacks and other reimbursements relating to purchases by Facility under the MedImmune contract with the exclusive GPO of choice must be data originating from the purchases of MedImmune product bearing MedImmune 11 digit National Drug Code, as assigned by the United States Food and Drug Administration. In addition, all applicable federal and state laws must be adhered to. The undersigned certifies on behalf of Facility that:

i) Facility's pharmacy(ies) that dispense(s) MedImmune products which are the subject of the Agreement between MedImmune and the exclusive GPO choice are located, licensed, and registered within the United States of America; and

ii) MedImmune products purchased under the MedImmune contract with the exclusive GPO of choice are for its "own use," and no products purchased under the MedImmune contract with the exclusive GPO of choice may be commercially resold or redistributed to any other entity or person. Sales and/or redistribution of said products to any other type of entity, account, or third party will be a violation of such contract and, in addition to pursuing any other remedies that MedImmune may have available at law or equity, MedImmune may terminate your right to receive products and/or reimbursements under said contract.

Authorized Signature: Date	Facility Name:
Printed Name:	Address:
Job Title:	City, State, ZIP Code:
Phone Number:	DEA: HIN:
Fax Number:	Email:

Please check √ the box which best describes your facility:

- ☐ Clinic
- ☐ HMO Facility
- ☐ Home Health Hospice
- ☐ Oncology Center
- ☐ Physician / Practitioner
- ☐ Rehabilitation Facility
- ☐ Surgery Center / Freestanding Surgical Facility
- ☐ Long Term Care (Nursing Home / Nursing Home Provider)
  (Nursing Home Provider – Sales of products purchased are limited to licensed nursing homes, approved correctional facilities, and other long-term care facilities for their own use.)
- ☐ Other (if checked, please specify)

Please return completed forms to: Membership@astrazeneca.com **or fax to the AZ Membership Team:** 302.886.4338

MEDIMMUNE INTERNAL PURPOSES ONLY
DEA/HIN #: _____ **CID #:** _____ **Receipt Date:** _____
Current Dedication: _____ **Entered By:** _____

This GPO Declaration Form will be effective 10 days from Receipt Date by MedImmune.
This Form contains confidential and sensitive information

PLEASE NOTE: All Facilities are subject to the approval of MedImmune. 11587 Revised 12/2015

PLEASE ALSO FAX OR EMAIL A COPY OF THIS FORM TO CCPA PURCHASING PARTNERS:

Fax: 888.276.2344 -OR- Email: aforman@ccpapp.org