ProviderSelect: MD™
Membership Application

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

Prospective 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 (Sponsoring Premier Owner/Purchasing Group): IPC Group Purchasing	Direct Parent Name (parent company, if different from Sponsor): CCPA Purchasing Partners, LP
Sponsor Entity Code: 636729	Direct Parent Entity Code: 700683

Prospective Member Relation to Direct Parent[1] *(If No Direct Parent, Indicate Prospective Member Relation to Sponsor):*

☐ Owned ☐ Leased ☐ Managed ■ Affiliated (Not Owned, Leased or Managed)

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

☐ Allergy & Immunology	☐ Family Practice	☐ Orthopedics	☐ Rehabilitation
☐ Cardiovascular Disease	☐ Infertility	☐ Otolaryngology	☐ Surgery
☐ Dentistry	☐ Internal Medicine	☐ Pain Management	☐ Urgent Care
☐ Dermatology	☐ Neurology	☐ Pediatrics	☐ Urology
☐ Ear, Nose & Throat	☐ OB/GYN	☐ Plastic Surgery	☐ Other
☐ Emergency Medicine	☐ Occupational Medicine	☐ Podiatry	
☐ Endocrinology	☐ Oncology	☐ Psychiatry	
☐ Gastroenterology	☐ Ophthalmology	☐ 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 provider_select@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 Prospective Member will not be participating in the pharmacy program, please write "Opt-out" below.

DEA #: HIN #:

Provider Select, LLC ("Provider Select") may share information with vendors, sponsors and other third parties in order to fulfill its obligations under the Provider Select program. For some programs and contracts, completion of specific participation forms may be required prior to obtaining contract pricing. Please contact provider_select@premierinc.com for more details.

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

1. The Provider Select medical/surgical group purchasing program contemplates as a goal that Prospective 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 program from the Provider Select distributor. Prospective Member further authorizes the Provider Select distributor to release total purchase data to Provider Select and Premier Healthcare Alliance, L.P. ("Premier") on a monthly basis.
2. Prospective Member hereby designates Provider Select to act as Prospective Member's purchasing agent for any and all medical, surgical, pharmacy [if Prospective Member participates in the Provider Select Pharmacy group purchasing program (the "Pharmacy Program")] and other products purchased by Prospective Member through Provider Select group purchasing programs. Prospective Member understands that Provider Select will act as Prospective Member's primary group purchasing organization.
3. Prospective Member is hereby notified that vendors pay to Provider Select or its affiliate, Premier, an administrative fee of three percent (3%) or less of the purchase price of goods and services such vendors provide. In the event there are any exceptions to the foregoing statement, Provider Select or Premier shall provide Prospective Member with an Administrative Fee Exceptions Schedule listing such exceptions. On an annual basis, Provider Select or Premier shall provide Prospective Member written notice of the amount of administrative fees which Provider Select or Premier has received from vendors with respect to purchases made by or on behalf of Prospective Member.
4. Prospective Member acknowledges and agrees that any action by Prospective Member which is inconsistent with the terms hereof may result in the termination by Provider Select, at Provider Select's sole discretion, of Prospective Member's participation in any or all Provider Select group purchasing programs. By signing this Membership Application, Prospective Member acknowledges its intent to: (i) participate in Provider Select group purchasing programs and (ii) comply with the participation requirements described herein.
5. This Membership Application may be canceled by either Provider Select or Prospective Member by giving at least thirty (30) days written notice of cancellation to the other.
6. Prospective Member represents that all products purchased under Provider Select and/or Premier negotiated agreements are for its own operations, excluding operations which compete with retail trade, and are not for resale.
7. During the term of this Membership Application and for a period of five (5) years thereafter, Prospective Member agrees to require individuals (employees, agents, designated representatives) with access to confidential information to keep confidential and not disclose to any third parties other than Provider Select and Premier or other employees of Prospective Member with a need to know (who have been made aware of this provision by the Prospective Member) any information designated as confidential by Provider Select or Premier by either oral or written statement without Provider Select's and/or Premier's prior written permission. Such confidential information may take many forms, but is likely to include Provider Select's and/or Premier's plans, reports, proposals, agreements, organizational documents, clinical studies, software, pricing information, and contract catalogs (printed and electronic).
8. Prospective Member agrees during the term of this Membership Application not to use any Provider Select or Premier agreements as leverage to negotiate individual or system agreements with Provider Select's or Premier's contracted vendors or other competing vendors that exclude Provider Select and Premier.
9. Prospective 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 Member, nor will Member provide to Premier, "protected health information," as such term is defined in HIPAA. For the avoidance of doubt, Prospective Member agrees that Premier is not engaging any supplier as its downstream business associate.
10. Prospective Member acknowledges that rebates or discounts it may receive from vendors as part of its participation in the Provider Select group purchasing program are, for purposes of 42 C.F.R. Section 1001.952(h), "discounts or other reductions in price" and Prospective 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 Prospective Members.
11. Prospective Member represents and warrants that its execution and performance of this Application does not conflict with or violate any other agreement or obligation to which Prospective Member is subject or by which it is bound.
12. Prospective Member acknowledges and agrees that Provider Select, its affiliates and their respective directors, officers, employees and agents will not be liable for the acts or omissions of its contracted suppliers, or for any representations or warranties made by such suppliers.
13. If Prospective Member participates in the Pharmacy Program, Prospective Member is required to abide by the following additional terms and conditions:
    a. Prospective Member agrees to purchase all of its annual requirements for pharmaceutical products which are covered by contract awards made by the Pharmacy Program through Premier group purchasing agreements.
    b. Prospective 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 Provider Select and Premier on a monthly basis.
    c. Prospective Member represents that all products and supplies purchased under Provider Select and/or Premier negotiated agreements are for its own operations, excluding operations which compete with retail trade, and are not for resale.
    d. Prospective Member understands that each manufacturer agreement has individual terms and conditions.

By signing below, Prospective Member hereby agrees to the foregoing terms of participation and confirms that all information supplied by Prospective member to Provider Select is complete and accurate. If Prospective Member is a Multi-Site System, Prospective Member hereby represents that it is authorized to sign this Membership Application on behalf of itself and each of the sites listed in Schedule 1 and that Prospective Member and each such site shall be bound by the terms of this Membership Application.

Signature of Prospective Member	Signature of Sponsor
Printed Name of Prospective Member	Printed Name of Sponsor
Title	Title
Date	Date

Email the completed application to applications@ccpapp.org or fax to 888.276.2344.

Schedule 1 – Child Site List

Please list all of Prospective Member's bill-to and ship-to sites that will be receiving products and services through the Provider Select program. By listing a site below, Prospective Member represents that 1) it has legal authority to sign and bind the site to contracts, including this membership application, and 2) it has control over all supply chain and purchased services for the site.

** A DEA # and/or HIN # must be provided for all sites that will be participating in the Premier Pharmacy 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 program. Some suppliers may require a DEA # (rather than a HIN) in order to provide access to program pricing.*

Bill to Address			**Ship to Address**		
Facility/Practice Name:		Phone Number:	Facility/Practice Name:		Phone Number:
Street Address:		Ste./Fl.:	Street Address:		Ste./Fl.:
City:	State:	Zip:	City:	State:	Zip:
DEA #:*	HIN #:*		DEA #:*	HIN #:*	
McKesson Account Number: (To be provided by the McKesson Account Manager)			*McKesson Account Number: (To be provided by the McKesson Account Manager)*		

Ship to Address			**Ship to Address**		
Facility/Practice Name:		Phone Number:	Facility/Practice Name:		Phone Number:
Street Address:		Ste./Fl.:	Street Address:		Ste./Fl.:
City:	State:	Zip:	City:	State:	Zip:
DEA #:*	HIN #:*		DEA #:*	HIN #:*	
McKesson Account Number: (To be provided by the McKesson Account Manager)			*McKesson Account Number: (To be provided by the McKesson Account Manager)*		

Ship to Address			**Ship to Address**		
Facility/Practice Name:		Phone Number:	Facility/Practice Name:		Phone Number:
Street Address:		Ste./Fl.:	Street Address:		Ste./Fl.:
City:	State:	Zip:	City:	State:	Zip:
DEA #:*	HIN #:*		DEA #:*	HIN #:*	
McKesson Account Number: (To be provided by the McKesson Account Manager)			*McKesson Account Number: (To be provided by the McKesson Account Manager)*		

If you have more addresses than can fit on this page, please re-use this page or email provider_select@premierinc.com for assistance.

Email the completed application to applications@ccpapp.org or fax to 888.276.2344.

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

LETTER OF GPO DESIGNATION

(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 _____ (GPO point of contact phone/email).

Name

Title

Healthcare Organization Name

Street

City, St, ZIP

Phone

Email

ACKNOWLEDGED:

_____

LETTER OF GPO DESIGNATION

EXHIBIT 1

(Healthcare Organization Name) Facilities Listing