



1940 124TH AVE NE
STE A105
Bellevue, WA 98005

Phone: 877-630-9198
Fax: 425-451-8964
Web: www.HyGenPharma.com

Customer Application Retailer/Physician – OTC and Rx – Checklist

Thank you for choosing to do business with HyGen Pharmaceuticals, Inc.
Please take a few minutes to fill out and fax or scan and email over the following items.

Description	
<input type="checkbox"/>	Credit Application Form – <u>Required</u> Completely filled out including 2 trade references.
<input type="checkbox"/>	Copy of Customer’s State License – <u>Optional</u> Required to purchase Rx Pharmaceuticals.
<input type="checkbox"/>	Terms and Conditions – <u>Required</u>
<input type="checkbox"/>	Duplicate and Deposit Faxed Checks – <u>Optional</u> Required if payment made by faxing copies of checks.
<input type="checkbox"/>	Credit Card Authorization – <u>Optional</u> Required if payment made by credit card.
<input type="checkbox"/>	WA State Resale Certificate – <u>Optional</u> Required for ALL WA Customers.
<input type="checkbox"/>	Prescription Drug Exemption Certificate – <u>Optional</u> Required for ALL WA customers.



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HyGen Sales Representative _____

Please fax **Completed Application, DEA License, and State Board of Pharmacy License** to 425-451-8964. If you have any questions, call toll free 877-630-9198.

Company Information:

Company Name: _____ DBA: _____

Billing Address: _____ Shipping Address: _____

City: _____ City: _____

State: _____ Zip: _____ State: _____ Zip: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____

State License #: _____ Exp. Date: _____

DEA #: _____ Exp. Date: _____

Tax ID #: ____-_____

Online Ordering:

Email: _____

Contact Information:

Contact Person for Purchasing:

Contact Person for Accounts Payable:

Name: _____

Name: _____

Phone/Extension: _____

Phone/Extension: _____

Email: _____

Email: _____

Trade References:

1. Company Name: _____ Contact Person: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____ A/C # _____

2. Company Name: _____ Contact Person: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____ A/C # _____

Primary Bank Information:

Bank Name: _____ Officer's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____

I hereby certify that the above information is true and correct. The information included in this application shall be used by HyGen Pharmaceuticals, Inc. to determine the amount of credit that can be extended to the above named company. I understand that HyGen Pharmaceuticals, Inc. may utilize other sources of credit, which it deems necessary in determining the credit status. I hereby authorize the bank & trade references to release the needed information listed above and also certify that I am authorized to execute this agreement.

Printed Name: _____ Title: _____

Signature: _____ Date: _____ Last Revised 04/29/2011



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Terms and Conditions – Retailer/Physician

Payments and Credits:

- Payment terms are **10 EOM for Generics and Net 7 Days for Brands** with approved credit unless negotiated differently. 10 EOM means payment for purchases in a given month are due by the 10th of the following month.
- We accept only **MasterCard** and **Visa** at the time of placing the order. See Credit Card Authorization Letter for details.
- Payments by check should be made payable to: **HyGen Pharmaceuticals, Inc.**
- Payment is due in accordance to the terms reflected on the invoice. We reserve the right to charge interest at the rate of 1.5% per month if payment is not made within those terms. We shall be entitled to recover reasonable attorney fees and costs in connection with any collection efforts, including but not limited to litigation arising out of failure to pay your invoice or statement.
- We will credit your payment to your oldest invoice or statement unless your remittance document reflects the invoice being paid or the payment exactly matches a specific invoice or statement amount.

Shipping:

- We provide free Ground shipping on orders greater than \$150.00.
- We offer 2 Day Air shipping on all orders over \$250.00 with the exception of liquids, suspensions & inhalers that are shipped by Ground only.
- All damages & shortages of products received **must be notified to us within 24 hours of receipt.**

Returns:

- Full credit will be given for shipping errors and products damaged in transit, provided the error or damage is reported to us within 24 hours of receipt of the product.
- All returns must be authorized in advance by obtaining a return authorization tag. The return box should be clearly marked "Return" on the outside of the box containing the returned products.
- HyGen Pharmaceuticals, Inc. reserves the right to authorize and accept returns for reasons other than shipping error or damage as long as the product is resalable. Credits for these returns will be given at the current market price of the returned product.
- We reserve the right to charge a **20% handling fee** to remove labels. If the removal of the price sticker damages the product package the package must be destroyed and credit cannot be issued.
- Products whose labels have been altered, defaced or damaged as deemed by HyGen Pharmaceuticals, Inc. are not eligible for credit.
- Any unauthorized returns will not be processed for credits.
- **No returns will be accepted on refrigerated items including vaccines or biological products.**
- We reserve the right not to accept bulk returns, returns from inactive accounts, accounts with outstanding balances or accounts in the process of closing.
- We reserve the right to return or destroy products that are ineligible for credit or are sent without prior authorization.
- Allow one to two weeks processing time for credit memos on authorized returns. Please do not deduct any amounts from your payment related to the returned product before receiving a credit memo.

Legal Requirements:

- State and Federal Law prohibits us from selling to unregistered and unlicensed health care professionals.
- All new customers need to fax us a copy of their valid State License. We will only ship to the address printed on the State License.

Pricing:

- All prices and quotes are provided as an offer and are subject to change without notice.
- We are committed to translate our volume purchasing power to offer increased savings to our valued customers.

I hereby acknowledge and accept the Terms and Conditions described above and that your Conditions of Sale will apply exclusively to all dealings between our companies.

Duly authorized for and on behalf of _____ Date: _____

Print Name _____ Signature _____



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Duplicate & Deposit Faxed Check Authorization Form

(Only required if paying by Faxed Check)

It is required that we have on file a note stipulating that HyGen Pharmaceuticals, Inc. is authorized to "Duplicate and Deposit" your faxed checks.

Please sign below and fax this Authorization back to us at 425-451-8964 so that we can have it on file.

Please mention "Duplicate and Deposit" on the check that is faxed to us along with the invoice numbers being paid.

Thank you,
Accounting Department
HyGen Pharmaceuticals, Inc.

I, _____, authorize HyGen Pharmaceuticals, Inc. to duplicate and deposit all faxed checks.

Company Name: _____

Signature: _____

Date: _____



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Credit Card Authorization Letter
(Only required if paying by Credit Card)

Note: All credit card orders are charged at the time of shipping the order.

I, _____, authorize the use of my credit card described below for charges related to all **generic purchases only** from HyGen Pharmaceuticals, Inc.

Note: Credit Cards are NOT accepted on purchases of any branded pharmaceuticals.

Please provide the following information **associated with the Credit Card**.

CC Type: _____ Visa or MasterCard

CC Number: _____

CC Expiration Date: _____

Name as on CC: _____

Company Name: _____

Billing Address: _____

City, State, & Zip Code _____

Phone Number: _____

Signature: _____

Date: _____

The amount charged is based on purchases requested by me and prices stated in Invoices I receive along with shipments.



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Resale Certificate
(WA Customers Only)

Please fax us a copy of your resale certificate along with a copy of your pharmacy license and other documents.

Thank You,

HyGen Pharmaceuticals, Inc.



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Prescription Drug Exemption Certificate
(WA Customers Only)

Name of Purchaser: _____

Address of Purchaser: _____

I hereby certify: That I am a registered Washington tax payer. I may legally prescribe or dispense drugs or other substances. I further certify that the drugs and other substances listed below purchased from _____ will be prescribed and used for the treatment of illness or ailments of human beings. I shall maintain invoices and prescriptions or such other records as are necessary to account for the disposition of the drugs or other substances for which I have not paid retail sales tax. In the event that any such drug or substance is used without a prescription being issued, it is understood that I am required to report and pay use tax measured by its purchase price. If I have indicated that this is a blanket certificate, this certificate shall be considered part of each order which I may hereafter give to you, unless otherwise specified, and shall be valid for a period of four years or until revoked by me in writing.

Description of drugs and other substances to be purchased:

Single Purchase: _____ **Blanket Certificate:** _____

(Indicate by checkmark if certificate is for a single purchase or continuing purchases.)

Authorized Agent or Purchaser:

Printed Name and Title: _____

Signature: _____

Date: _____