HyGen™ Pharmaceuticals, Inc.

8635 154th Ave NE
Suite 100
Redmond, WA 98052

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

Customer Application
Independent – 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
☐	Credit Application Form – Required Completely filled out including 2 trade references.
☐	Copy of Customer's State License – Required Required for all new customers.
☐	Copy of Customer's DEA License – Required Required for all new customers.
☐	Terms and Conditions – Required Required for all new customers.
☐	California POD – Optional Required if pharmacy is located in California.
☐	Duplicate and Deposit Faxed Checks – Optional Required if payment made by faxing copies of checks.
☐	ACH Payment Authorization Form – Optional Required if payment made by ACH.
☐	WA State Resale Certificate – Optional Required if pharmacy is located in Washington State.
☐	Prescription Drug Exemption Certificate – Optional Required if pharmacy is located in Washington State

HyGen™ Pharmaceuticals, Inc.

8635 154th Ave NE
Suite 100
Redmond, WA 98052

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

Please email **Completed and signed Application**, **DEA License**, and **State Board of Pharmacy License** to sales@hygenpharma.com. If you have any questions, call toll free 877-630-9198.

Company Information:

Company Name: _____ DBA: _____

Business Type: ☐Retail / Warehousing ☐Retail / Non-Warehousing ☐LTC

☐Mail Order ☐ Institutional/Hospice ☐ Specialty ☐ Other _____

Average Scripts per Day: _____ Specialty: _____

Billing Address: _____ **Shipping Address**: _____

City: _____ City: _____

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

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

Tax ID #: ___-_____ **Online Access Email**: _____

Contact Information:

Contact Person for Purchasing:

Name: _____

Phone/Extension: _____

Email: _____

Contact Person for Accounts Payable:

Name: _____

Phone/Extension: _____

Email: _____

Trade References:

Primary Vendor: _____ Other Vendor: _____

GPO Membership: _____ HIN: _____ GLN: _____

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 (Owner/Officer):_____ Title: _____

Signature: _____ Date: _____

HyGen™ Pharmaceuticals, Inc.

8635 154th Ave NE
Suite 100
Redmond, WA 98052

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

Terms and Conditions

Payments and Credits:

- Customer agrees to pay HyGen Pharmaceuticals, Inc. ("HyGen") at **10 EOM** for Generics, and at **Net 7** for Brand items with approved credit, unless mutually agreed otherwise in writing.
- Payments by check should be made payable to: **HyGen Pharmaceuticals, Inc.**
- HyGen shall charge Customer a $30 fee for any bounced check or ACH Transaction rejected due to non-sufficient funds.
- Customer shall pre-pay for orders if paying by credit card. HyGen accepts MasterCard, Visa, and American Express at the time of shipping.
- Customer shall pay HyGen in accordance to the terms reflected on the invoice. Customer shall pay HyGen interest at the rate of 1.5% per month on all amounts past due.
- HyGen shall credit Customer's payment to the oldest invoice or statement unless Customer's remittance document reflects the invoice being paid or the payment exactly matches a specific invoice or statement amount.
- Credits for returned goods are subject to the most current version of HyGen's Returned Goods Policy.

Shipping:

- HyGen provides free ground shipping on all generic orders greater than $100.00.
- Bulk quantities, hazardous items, liquids, suspensions & inhalers are shipped via Ground only.
- Any damage, product shortage, or other discrepancy **must be notified to HyGen within one business day of delivery** to be eligible for credit.

Governing Law:

- This Agreement shall be governed by the Laws of the State of Washington. The Parties hereby irrevocably submit to the exclusive jurisdiction of any federal or state court located within the County of King, State of Washington over any dispute arising out of or relating to this Agreement or any of the transactions contemplated hereby and agree that all claims in respect of such dispute or any suit, action proceeding related thereto may be heard and determined in such courts.

Personal Guarantee:

- The undersigned personally guarantees the prompt and full performance of all obligations due and owing by Customer to HyGen under this and/or any other agreement with HyGen. The undersigned waives presentment, demand, protest, notice of protest, notice of dishonor and any and all other notices or demands of whatever character to which the undersigned might otherwise be entitled. The undersigned further consent to any extension granted by HyGen and waives notice thereof. If more than one guarantor, the obligation of each shall be joint and several. Termination of this guarantee must be in writing, signed by HyGen and undersigned, and in such event, shall only apply as to future obligations.
- In the event of default in any payment or other obligation to HyGen, Customer agrees to reimburse HyGen for any and all attorney's fees, court and other costs and expenses reasonably incurred in collecting or enforcing these Terms and Conditions.

I hereby acknowledge and accept the Terms and Conditions described above and agree that they shall apply exclusively to all dealings between our companies.

Duly authorized for/on behalf of (company name) _____, as well as by the undersigned in his/her personal capacity as Guarantor:

Print Name _____ Title: _____

Signature_____ Date: _____

HyGen™ Pharmaceuticals, Inc.
8635 154th Ave NE
Suite 100
Redmond, WA 98052
Phone: 877-630-9198
Fax: 425-451-8964
Web: www.HyGenPharma.com

ACH Payment Authorization Form

Customer Name: _____

Customer Account #: _____

Schedule your payment to be automatically deducted from your checking or savings account.
To get started, complete and sign this form and attach a voided check!

ACH Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges

Here's How ACH Payments Work:
You authorize monthly scheduled charges to your checking or savings account. You will be charged the amount indicated below each billing period. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us prior to charging the account.

Please complete the information below:

I _____ authorize HyGen Pharmaceuticals Inc., to charge my bank account indicated below at 10 EOM for generic purchases and at Net 7 for brand purchases, with approved credit, unless other terms have been mutually agreed upon in writing.

Billing Address: _____

Phone# _____ Email: _____

Account Type: ☐ Checking ☐ Savings

Name on Acct _____

Bank Name _____

Account Number _____

Bank Routing # _____

Bank City/State _____

SIGNATURE _____ DATE _____

Customer understands that this authorization will remain in effect until Customer cancels it in writing, and Customer agrees to notify HyGen Pharmaceuticals, Inc. in writing of any changes in payment account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted periodic payment dates fall on a weekend or holiday, Customer understands that the payment may be executed on the next business day. Customer understands that because this is an electronic transaction, these funds may be withdrawn from Customer's account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that HyGen Pharmaceuticals, Inc. may at its discretion attempt to process the charge again within 7 days, and agree to an additional $30/- charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. Customer acknowledges that the origination of ACH transactions to Customer's account must comply with the provisions of U.S. law. Customer agrees not to dispute this ACH payment with Customer's bank so long as the transactions correspond to the terms indicated in this authorization form.

HyGen™ Pharmaceuticals, Inc.

8635 154th Ave NE
Suite 100
Redmond, WA 98052

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

Returned Goods Policy

- All returns must be authorized in advance by contacting Customer Service and obtaining written authorization.
- A 20% restocking fee will be assessed on all returned goods, with the exception of returns due to in-transit damage or any discrepancy caused by HyGen.
- If the removal of price stickers damages the product package, the product is ineligible for credit and will be destroyed.
- Products whose labels have been altered, defaced or damaged as deemed by HyGen Pharmaceuticals, Inc. are not eligible for credit.
- No returns will be accepted on cold chain items, controlled substances, items which have been special ordered for Customer, or items which are otherwise indicated as non-returnable.
- HyGen reserves the right to destroy products that are sent without prior authorization. Credit will not be issued for such items.
- HyGen reserves the right to refuse bulk returns, returns from inactive accounts, accounts with overdue balances, or accounts in the process of closing
- HyGen reserves the right to refuse any and all returns from Customer if HyGen suspects the goods may be counterfeit, adulterated, unsaleable, outdated, or otherwise not in compliance with the Returned Goods Policy, or if Customer has previously attempted to return such goods to HyGen.
- Restocking, handling, and return freight charges may be deducted from return credit at HyGen's discretion.
- 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.

HyGen™ Pharmaceuticals, Inc.

8635 154th Ave NE
Suite 100
Redmond, WA 98052

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

California POD Signature

Dear Pharmacy Manager or Pharmacist in Charge,

The California State Board of Pharmacy Law Business and Professions code section 4059.5 states the following:

(a) Except as otherwise provided in this chapter, dangerous drugs or dangerous devices may only be ordered by an entity licensed by the board and shall be delivered to the licensed premises and signed for and received by a pharmacist. Where a licensee is permitted to operate through a designated representative, the designated representative may sign for and receive the delivery.

(b) A dangerous drug or dangerous device transferred, sold, or delivered to a person within this state shall be transferred, sold, or delivered only to an entity licensed by the board, to a manufacturer, or to an ultimate user or the ultimate user's agent.

PHARMACY TECHNICIANS AND OTHER PHARMACY EMPLOYEES ARE NOT PERMITTED TO SIGN FOR ANY PRESCRIPTION OR CONTROLLED SUBSTANCE DRUG ORDERS.

While we understand and appreciate this may take additional time, this is a compliance requirement, so we ask that you please cooperate with the delivery requirements and assist us in remaining compliant by having your pharmacist receive and sign for your delivery.

Please fill in the lines below of the designated licensed pharmacist who is authorized to sign for deliveries of prescription and control drugs. Only these representatives may sign for deliveries from HyGen Pharmaceuticals.

COMPANY INFORMATION			
Full Legal Name/Business Entity	Phone #		Fax #
Doing Business As (DBA)			
Street Address	City	State	Zip Code

DESIGNATED LICENSED PHARMACIST				
1	First Name	Middle Name	Last Name	Title
	Signature			
2	First Name	Middle Name	Last Name	Title
	Signature			
3	First Name	Middle Name	Last Name	Title
	Signature			
4	First Name	Middle Name	Last Name	Title
	Signature			

HyGen™ Pharmaceuticals, Inc.

8635 154th Ave NE
Suite 100
Redmond, WA 98052

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

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: _____

HyGen™ Pharmaceuticals, Inc.

8635 154th Ave NE
Suite 100
Redmond, WA 98052

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

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.

HyGen™ Pharmaceuticals, Inc.

8635 154th Ave NE
Suite 100
Redmond, WA 98052

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

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 the certificate is for a single purchase or continuing purchases.)

Authorized Agent or Purchaser:

Printed Name and Title: _____

Signature: _____

Date: _____