

Account Set-Up Survey

Company Name: _____ Phone: _____

Address: _____ Email: _____

1) Please describe your business type:

- Chain Pharmacy Warehouse
- Distributor
- Government facility
- Institutional (hospital/state/federal prison)
- Long-term care
- Mail order pharmacy
- Wholesaler
- Other: Please describe

2) Do you have a valid state board of pharmacy license?

- Yes (if yes please provide state board number) _____
- No

3) Who is your primary wholesaler? _____

4) What sources have you used to purchase Major/Rugby products in the past? _____

5) What types of products do you expect to purchase from Major/Rugby?

(Check all that apply)

- OTC Drugs
- Vitamins/Dietary Supplements
- List-1 OTCs
- Prescription
- Controlled Substances

6) Please provide forecasted monthly quantities you expect to purchase from Major/Rugby:

Type of Product	Number of Products	Total Bottles Monthly
OTC Drugs		
Vitamins/Dietary Supplements		
List-1 OTCs		
Prescription		
Controlled Substances		

7) Please indicate the customer categories which you service (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Distributors | <input type="checkbox"/> Pain Clinics |
| <input type="checkbox"/> Hospitals | <input type="checkbox"/> Export |
| <input type="checkbox"/> Physicians | <input type="checkbox"/> Chains |
| <input type="checkbox"/> Narcotic Treatment Programs | <input type="checkbox"/> Direct Patients |
| <input type="checkbox"/> Retail Pharmacies | <input type="checkbox"/> Other <i>(please describe)</i> : _____ |
| <input type="checkbox"/> Veterinary | |

Signature

Printed Name

Date