TheraCom®
AmerisourceBergen Consulting Services

9717 Key West Avenue
Rockville, MD 20850
Telephone: (866) 647-3646
Fax: (888) 281-8199

Physician License Information:

Name: ________________________

License No: ________________________

Address: ________________________
____

Entity Name and Address:

Name of Entity: ________________________

Address: ________________________
____

Contact Person: ________________________
Phone No.: (____)__________________

Additional shipping addresses may be listed below.

To TheraCom, LLC and its Affiliates:

The undersigned physician certifies that he/she (a) is affiliated with the entity and location identified above and any additional shipping locations listed below, (b) will be responsible in all respects for the receipt, recordkeeping, storage, handling and accountability of pharmaceutical products shipped to the entity at such location(s), and (c) will immediately notify you if either of the foregoing statements is no longer true.

This certification and authorization does not apply to shipment of controlled substances.

NOTHING IN THIS DOCUMENT CREATES ANY FINANCIAL OBLIGATION ON THE UNDERSIGNED PHYSICIAN TO PAY FOR ANY PRODUCTS.

(Optional) I authorize the following representatives to accept and be responsible for pharmaceuticals delivered to the shipping address(es): Print Name(s): ____

PHYSICIAN SIGNATURE REQUIRED: (must match name on license)

Signature: ______________________

Print Name: ______________________ Date: ______________________

NOTE: **You MUST submit to TheraCom, LLC:**

- A copy of a valid license reflecting the license holder's name AND
- Evidence that each shipping address is your medical office (acceptable evidence includes a business card or letterhead that reflects the shipping address).

Additional Shipping Addresses (optional):

Shipping Address:

Name of Location: (if different from above) ________________________

Address: ________________________
____

Contact Person: ________________________
Phone No.: (____)__________________

Shipping Address:

Name of Location: (if different from above) ________________________

Address: ________________________
____

Contact Person: ________________________
Phone No.: (____)__________________