

Membership Agreement



As an authorized agent for: _____, _____,
I, _____, _____ hereby
authorize and appoint National Discount Vaccine Alliance, Inc. (NDVA)
as our group-purchasing agent for the purpose of recommending and
endorsing goods and services for our use as long as this Group Purchasing
Program Membership Agreement remains in effect.

6750 SW 29th St • Topeka, KS 66614
785-273-4165 • 785-273-4149 Fax

AS A MEMBER OF NDVA, I AGREE TO KEEP ALL PRICING AND CONTRACT INFORMATION CONFIDENTIAL.
Furthermore, I recognize that the purchasing programs offered by NDVA may include an administrative fee paid by the contracted
vendors to NDVA. Such compensation may be a fixed amount or a percentage of the value of purchases made by your Practice from a
vendor, but in no case shall it exceed three percent (3%) without appropriate notification to your Medical Practice.

Furthermore, I understand that each vendor's (manufacturer or distributor) contract requires that I expressly designate my intention
to purchase products under the terms of the NDVA agreement by signing the vendor's Contract Designation Form. Membership in
NDVA does not automatically provide access to NDVA's vendor contracts. I agree to review each vendor's Contract Designation Form
that I intend to use and abide by any conditions contained therein.

NDVA represents and warrants that its Group Purchasing Program and related activities comply with applicable state and Federal
laws, including the relevant provisions of the Federal "Safe Harbor" regulations found at 42 CFR 1001. Your Medical Practice, by
executing this Agreement, agrees to disclose and appropriately reflect any discount or reduction in price received in any cost report
submitted to any governmental programs, including but not limited to, the Medicare and Medicaid programs.

This Group Purchasing Program Membership Agreement shall remain in effect for one year from the date of signature unless
terminated by either party upon thirty (30) days advance written notice. Unless otherwise notified, this agreement shall renew for
additional one-year periods on the anniversary date each year hereafter.

PLEASE COMPLETE THE FOLLOWING INFORMATION

Name of Practice: _____

Print Name: _____ Title: _____
(person completing form)

DEA # for your main office: _____ (this will be your NDVA Account #)

Primary Office Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext.: _____ Fax: _____

Email: _____

Website: _____

Managing Physician: _____ (M.D. / D.O.) _____

Type Of Practice: _____
(Pediatric, Family Practice, Internal Medicine, etc.)

Practice Manager: _____ Title: _____

Practice Purchasing Agent: _____ Title: _____

Practice E-mail Address: _____

of Office Locations: _____ # of Providers _____ Physicians _____ Nurse Practitioners _____

P.A.s _____

PLEASE SIGN

Authorized Signature: _____ Date: _____

Print Name: _____ Title: _____

Please fax Membership Agreement to:
Denise Province, Contract Administrator (785) 273-4149 or email to dprovince@nationaldiscountvaccinealliance.com

Membership Agreement for Merck Vaccines

The following is an agreement to join National Discount Vaccine Alliance, Inc in a purchasing agreement with Merck Vaccines.

_____ representing all providers
of _____ with the address of _____
and NDVA Member # _____.

We agree to the terms and conditions of the pricing. NDVA and its member practices will not prefer or utilize, either directly or indirectly any competing product over any Merck product except for explicit reasons of medical necessity or as provided by specific contract exemption. Any office that does not comply with purchasing Recombivax, Vaqta, MMR, Varivax, Pneumovax 23, RotaTeq, and Gardasil at a minimum level of 90% will be considered non-compliant and subject to immediate removal from the contract. This will be monitored no less than quarterly.

We have had the opportunity to ask questions and understand the purchasing process of NDVA. We understand that our participation includes all physicians in the practice to this exclusive agreement.

Physician Name _____ Merck Account number _____

Physician Signature _____ Email address _____

DEA Number (NDVA Member #) _____ Phone number _____

**Return by email to dprovince@nationaldiscountvaccinealliance.com
or by Fax (785) 273-4149.**

Please log in to nationaldiscountvaccinealliance.com for specific member pricing.



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Membership Agreement for sanofi pasteur

The following is an agreement to join National Discount Vaccine Alliance, Inc in a purchasing agreement with sanofi pasteur vaccines.

_____ representing all providers
of _____ with the address of _____
and NDVA Member # _____.

We agree to the terms and conditions of the pricing. NDVA and its member practices will not prefer or utilize, either directly or indirectly any competing product over any sanofi pasteur product except for explicit reasons of medical necessity or as provided by specific contract exemption. Any office that does not comply with purchasing of Act HIB, tripedia or Daptacel, Adacel, Pentacel, and IPOL will be subject to termination from the contract. In order to be compliant, each office must maintain a vaccine purchase percentage at a minimum level of 90% and must maintain 95% of their prior year's Fluzone purchases. All accounts less than 90% will be considered non-compliant and subject to immediate removal from the contract. This will be monitored no less than quarterly.

We have had the opportunity to ask questions and understand the purchasing process of NDVA. We understand that our participation includes all physicians in the practice to this exclusive agreement.

Physician Name _____ sanofi pasteur account number _____
Physician Signature _____ Email address _____
DEA Number (NDVA Member #) _____ Phone number _____

**Return by email to dprovince@nationaldiscountvaccinealliance.com
or by Fax (785) 273-4149.**

Please log in to nationaldiscountvaccinealliance.com for specific member pricing.



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