



160 Tower Drive  
Burr Ridge, IL 60527-5720  
(630)-655-4000  
FAX # (630)-655-6315

Today's Date \_\_\_\_\_ Application Taken By \_\_\_\_\_

**CREDIT APPLICATION**

**COMPANY INFORMATION**

Legal Business Name \_\_\_\_\_

D/B/A Name \_\_\_\_\_

Company Name \_\_\_\_\_

Type of Ownership: Sole Proprietor  Partnership  Corporation  Other  State of Incorporation \_\_\_\_\_

Owner's Name \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-Mail \_\_\_\_\_

Duns Number \_\_\_\_\_ Number of Years in Business \_\_\_\_\_

Years at this Address \_\_\_\_\_ Date Business came under control of present owner(s) \_\_\_\_/\_\_\_\_/\_\_\_\_

Type of Business: Pharmacy  Home Health  Hospital  Other  (list) \_\_\_\_\_

Estimated Monthly Sales Volume (Dik Drug) \_\$ \_\_\_\_\_ Credit Line Requested (Dik Drug) \_\$ \_\_\_\_\_

Estimated Monthly Sales Volume (DHC) \_\$ \_\_\_\_\_ Credit Line Requested (DHC) \_\$ \_\_\_\_\_

Billing/Statement Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Billing Contact \_\_\_\_\_ Title \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

A/P Supervisor \_\_\_\_\_ Phone \_\_\_\_\_

**LICENSING INFORMATION**

\*\*\*\*\* ATTACH A COPY OF ACTUAL LICENSE/CERTIFICATE/LETTER\*\*\*\*\*

DEA License # \_\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_ 2 2N 3 3N 4 5

State Pharmacy License \_\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

State Resale Tax # \_\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Sales Tax Exempt # \_E\_\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

National Provider Identifier (NPI) # \_\_\_\_\_

**ILLINOIS CUSTOMERS MUST INCLUDE A SIGNED CRT 61; INDIANA CUSTOMERS MUST INCLUDE A SIGNED ST105, WISCONSIN CUSTOMERS MUST INCLUDE SIGNED S211 AS REQUIRED BY YOUR STATE FOR TAX PURPOSES.**

The undersigned Dik Drug Co. representative acknowledges they have conducted a personal visit and site inspection to validate this pharmacies operation. It conducts business in the manner indicated in their response and completion of the Dik Drug Co. Customer Class of Trade Inquiry document.

Printed name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**TRADE REFERENCE**

⇒  
 ⇒ Company Name \_\_\_\_\_ Acct # \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Contact \_\_\_\_\_ Fax # \_\_\_\_\_  
 ⇒ Company Name \_\_\_\_\_ Acct # \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Contact \_\_\_\_\_ Fax # \_\_\_\_\_

PLEASE SELECT OTHER WHOLESALERS/MANUFACTURERS YOU HAVE ACCOUNTS WITH FOR ADDITIONAL TRADE INFORMATION

- AMERISOURCE/BERGEN     CARDINAL     MCKESSON     HD SMITH   
 ANDA     PRIDE     SUNRISE

**BANK REFERENCE**

Bank Name \_\_\_\_\_  
 Account Number \_\_\_\_\_ Contact \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Note: If you are an ACH customer please initial in the appropriate space provided indicating division(s) authorized to draft from your account for payment purposes. Proper paperwork must accompany application.**

Authorize Dik Drug \_\_\_\_\_ Authorize DHC \_\_\_\_\_ Authorize Both DDC & DHC \_\_\_\_\_

**Signature Required in this section by all applicants in order that credit information may be obtained.**

I/we hereby apply for credit. The information and statements in this application are true and complete, and are made for the purpose of inducing you to establish an open account line of credit for me/us. You are hereby authorized to obtain from any source any information necessary to verify the statements in this application, and a photocopy of this application shall serve to authorize such sources to disclose information to you.

**X Signature of Applicant** \_\_\_\_\_ Date \_\_\_\_\_ Title \_\_\_\_\_  
 (Signature of duly authorized representative required)

Financial statements may be required based upon the requested line of credit. The above signature acknowledges and accepts the terms and agreements outlined on this credit application on page 3 – Terms and Conditions.

**APPROVAL TO RECEIVE UNSOLICITED ELECTRONIC DATA/CLASS OF TRADE STATEMENT**

- I agree to receive unsolicited faxes, e-mails and other mail from Dik Drug Company
- I would prefer not to receive unsolicited faxes, e-mails and other mail from Dik Drug Company
- I am a properly licensed Wholesale Distributor of Drugs
- I require pedigree with my shipments

**X Initials of applicant** \_\_\_\_\_





**Controlled Substances Act of 1970 (CSA)**  
**Prescription Drug Marketing Act of 1987 (PDMA)**

The Controlled Substances Act of 1970 requires non-practitioners to make good faith inquiries to determine whether persons are authorized to handle controlled substances and to monitor ordering practices to determine whether registrants are making excessive or unusual purchases. Suspicious orders must be reported to the local office of the Drug Enforcement Administration.

Also, effective December 1, 2006 the FDA was scheduled to implement final pedigree legislation as required in the Prescription Drug Marketing Act originally enacted in 1987. Currently a court issued injunction has delayed this implementation but preparation for the pending implementation is necessary.

Dik Drug Co. supports federal drug legislation and its intent to strengthen the safety of the pharmaceutical supply chain and minimize the impact of drug diversion and misuse.

To comply with the implementation of law it is necessary for Dik Drug to identify any customer engaged in the wholesale distribution of pharmaceutical products. To clarify, the definition of a wholesale distributor is as follows:

**Anyone engaged in wholesale distribution of drugs, including: manufacturers; repackers; own-label distributors; private-label distributors; jobbers; brokers; warehouses(including manufacturers' and distributors' warehouses), chain drug warehouses, and wholesale drug warehouses; independent wholesale drug traders; and retail pharmacies that conduct wholesale distributions in the amount of at least 5% of gross sales.**

**Dik Drug is also interested in knowing whether customers are involved with some specific business practices: 1. Servicing an identifiable pain management medical practice 2. Compounding for hospitals or other businesses.**

By identifying customers in this manner, Dik Drug can also use this information to assure, based on both federal and individual state laws, that it is in full compliance in supplying pedigree as per applicable law.

Please complete the included document and fax it to Customer Service at 630-321-0471.

Thank you for your cooperation.



**Customer Class of Trade Inquiry**

Account Name \_\_\_\_\_ Acct # \_\_\_\_\_

1. Does your business maintain a pharmaceutical wholesale/distributor license? YES NO

If yes, please denote the type of wholesale distribution you provide and/or the customer base served:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Do you warehouse or distribute pharmaceutical product to any pharmacy not under your ownership? YES NO

3. Controlled Substance Utilization

Of your total Rx purchases from Dik Drug, what % will be controlled substances? \_\_\_\_\_%

Of the controlled substance purchases, what % will be comprised of oxycodones, hydrocodones, and alprazolam? \_\_\_\_\_%

Average number of controlled substance prescriptions filled per day \_\_\_\_\_

Please list other wholesale distributors used to purchase controlled substances. Please note (N/A) if not applicable. \_\_\_\_\_

4. Do you service an identifiable pain management medical practice? YES\* NO

5. Have you ever had a DEA registrations suspended, revoked, or denied? YES\* NO

6. Has any owner been convicted of a drug related felony? YES\* NO

\*If yes to questions 4, 5, or 6 please attach a separate explanation with supporting detail.

**Please list additional accounts (account number) under same ownership if responses are identical:**

\_\_\_\_\_

Please certify that you, under penalty of perjury, operate within the laws and rules of the governing state and the federal DEA as a licensed \_\_\_\_\_ (retail pharmacy, wholesale distributor) of pharmaceutical products and that the information included is true and correct. Further, the undersigned hereby certifies that it does not engage in "internet pharmacy" activity and is not affiliated with or knowingly participating in any "internet pharmacy" activity, and that it makes all reasonable efforts to ensure that its customers or sub-accounts are not engaged in any "internet pharmacy" activities.

Customer/Authorized Officer Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Return to your business development manager or fax to Dik Drug Customer Service at (630) 321-0471.

**It is the policy of Dik Drug Co. that no controlled substance purchases will be allowed until a personal site visit is conducted, the customer class of trade survey is completed, and the appropriate review of the DEA Compliance Committee has been completed.**

**It is further required that the licensee report any business changes or practices that would materially change any responses included in this inquiry.**