Mercedes Scientific
Pharmaceutical Questionnaire

PLEASE COMPLETE ENTIRE FORM, SIGN AND DATE

This questionnaire is to be completed by the Owner/Manager or Authorized Pharmacist in charge.

Business Name: _____

Business Address: _____

City, State, Zip: _____ Business Ph. _____

Is this facility affiliated with a hospital? Yes _____ No _____

Has the Business ever had a DEA registration or State license suspended or revoked?

Yes _____ No _____

Please attach a copy of the following.

Business DEA registration #: _____ Expire Date: _____

State Department of Health License #: _____ Expire Date: _____

Health Care Clinic Establishment (HCCE) #: _____ Expire Date: _____
(Required for Florida Customers)

I,_____("Customer") as the owner/representative, have completed this form to the best of my knowledge and ability. The customer agrees that it will abide by all applicable laws, rules, regulations, ordinances and guidelines of the federal Drug Enforcement Administration (DEA), the United States Food and Drug Administration (FDA), the states into which it dispenses controlled substances and the states in which it is licensed.

Customer agrees that failure to comply with this agreement may result in termination of the relationship between Mercedes Scientific and Customer, in whole or in part notwithstanding any other agreements to the contrary.

_____ _____

Signature Date

Please return completed questionnaire & licensing to Mercedes Scientific
via fax: 800-359-8807 | email: Rx@MercedesScientific.com