## GROUP PURCHASING ORGANIZATION MEMBERSHIP DECLARATION w/ SURVEY

In order to take advantage of prices and/or rebates under a Group Purchasing Organization (GPO) or Alliance with GSK contracts, GSK requires an eligible facility to designate only **ONE** GPO whose contract(s) said facility will access to purchase GSK products. **The GPO designation listed below, if different from current files, will remove facility from their current GPO (or other segment) within 30 days of notification.**
Multiple GPO designations, even for different product groups, will not be honored. Designations may be changed but will require thirty (30) days advance written notice to GSK. GSK reserves the right to refuse to extend a contract price to a facility that has failed to designate a GPO/Alliance, seeks to purchase under agreements with multiple alliances, or does not meet contract eligibility requirements. Facility will be added to the designated GPO's contract(s) within thirty (30) days, if GSK determines that all contract eligibility requirements are met. Declaration forms must be submitted for each location.

**PLEASE COMPLETE ALL REQUESTED INFORMATION (PLEASE PRINT) INCOMPLETE FORMS WILL NOT BE PROCESSED**

FACILITY NAME _____

DEA or HIN # (must be current) _____ STATE LICENSE #_____ STATE LICENSE # EXPIRATIONDATE _____

FACILITY STATE LICENSE NAME OR AUTHORIZED Health Care Provider STATE LICENSE NAME _____
PHYSICAL ADDRESS _____ SUITE # _____

CITY _____ STATE _____ ZIP _____

TELEPHONE _____ FAX # _____

**MUST DESIGNATE SOLE GROUP PURCHASING ORGANIZATION**: _____
PRIMARY WHOLESALER (NAME, CITY, STATE)_____

TYPE OF BUSINESS:

- ☐ On-site hospital clinic
- ☐ Off-site satellite clinic (affiliated with _____ Hospital)
- ☐ City County or State (CCS) funded health clinic
- ☐ Surgery Center
- ☐ HMO/Managed health care
- ☐ Intermediate Care Facilities for Mentally Retarded
- ☐ Outpatient Clinic in a Hospital
- ☐ Hospice Inpatient
- ☐ Inpatient Psychiatric Facility
- ☐ Outpatient Mental Health Clinic
- ☐ Public Health Department
- ☐ Hospital owned and funded by government
- ☐ Correctional Facility
- ☐ Other (please describe: _____)

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| Is this facility owned, leased, or managed by a hospital or hospital system? | YES | NO |
| If so, name and location of hospital or hospital system _____ | | |
| Is a pharmacy or physician-dispensing unit physically located within this facility? | YES | NO |
| Is this pharmacy or physician dispensing unit a closed-door pharmacy? (i.e. only serves patients and employees of the facility?) | YES | NO |
| Is this facility for profit? | YES | NO |

**CERTIFICATION: By signing below, Facility certifies, under penalty of perjury, that all of the above information is true and correct. Further, Facility certifies and agrees that (1) any GSK product purchased under any agreement shall be for its "Own Use," as defined by the United States Supreme Court in its opinions report at Abbott Laboratories et al. v. Portland Retail Druggist Association, Inc., 425 U.S. 1 (1976), and Jefferson County Pharmaceutical Association, Inc., v. Abbott Laboratories, et al., 103 S. Ct. 1011 (1983), and (2) GSK may, in its sole discretion, contact Facility's staff, and/or visit Facility's locations to verify that the above information is correct, and Facility agrees to provide such information to GSK as is reasonably necessary for GSK to make such a determination.**

_____

Printed Name *(Required)* Title *(Required)* Signature *(Required)* Date *(Required)*

*PLEASE FAX FORM BACK TO 215-933-3947 OR EMAIL TO: iqq86213@gsk.com*