

Send your completed Registration Form to:  
**Distribution@DSuccess.com or Fax 855-345-6789**

A Direct Success Representative will contact you to confirm your registration.

### Institution Information

NAME OF INSTITUTION

REQUESTERS FULL NAME

ADDRESS

STE / DEPT.

POSITION / TITLE

CITY / STATE / ZIP

PHONE #

PHONE #

FAX #

FAX #

EMAIL

INSTITUTION LICENSE # (HIN#)

340B / PHS (Public Health Service) eligible:  YES  NO

If yes, please provide entity ID # \_\_\_\_\_

PHARMACY LICENSE #

FSS (Federal Supply Schedule) eligible:  YES  NO

If yes, please provide parent agency \_\_\_\_\_

### Financial / Billing

CONTACT

Do you choose to use a credit card as your payment method:

YES (If yes, a representative will contact you to complete the information.)

NO

PHONE #

If you choose, **NOT** to pay by credit card, complete the following information below and provide the last two years of P&L statements and the most recent IRS Form W-9.

EMAIL

Bill to:

DEPARTMENT / ATTENTION

DUN & BRADSTREET #

ADDRESS

TAX IDENTIFICATION NUMBER (EIN)

CITY / STATE / ZIP

**Certification:** The above information is for the purpose of obtaining commercial credit and is warranted to be true and correct. If Direct Success, Inc. considers a credit report relevant and necessary to assisting this request for credit, the undersigned authorizes Direct Success, Inc. to obtain from a credit reporting agency a credit report containing credit information about the applicant. A copy of this application shall be deemed as an original.

AUTHORIZED CONTACT (Print First and Last Name)

TITLE

AUTHORIZED SIGNATURE

DATE

### THIS SECTION TO BE USED FOR INTERNAL USE ONLY:

Before completing this section, please check all required information below has been provided.

VERIFIED:  Institution License  Pharmacy License  340B Eligibility  
 FSS Eligibility  Class of Trade

Print Name (First and Last Name) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_