NEW CUSTOMER APPLICATION

Print Form

(Please print in block letters)

Public Health Sector Qualified: ◯ **Yes** ◯ **No** **If "Yes," provide 340B ID**

Customer Information:

Company Name | Website Address | Fax Number

Address | City | State | Zip Code

Contact Name regarding questions about this application | Title | Phone | Email

Billing Information: (Where invoices will be sent)

Company Name | Phone | Fax Number

Address | City | State | Zip Code

Payer Information: (Where invoices will be paid)

Company Name | Phone | Fax Number

Address | City | State | Zip Code

AP Contact Name | Phone | Email Address

Shipping Information for each Ship-to Location:

In order to comply with Federal, State and Local Regulations, JOM Pharmaceutical Services, Inc. will ship product strictly to properly registered businesses. You may include additional sheets to add more ship-to locations.

Company Name | Phone | Fax Number

Address | City | State | Zip Code

Company Name | Phone | Fax Number

Address | City | State | Zip Code

Banking and Other Information:

◯ Paying via ACH
- ◯ EFT [Preferred method; provide contact for testing if EDI]
  - ◯ CTX [Preferred]
  - ◯ CCD
  - ◯ Bank Wire

◯ Paying by Check [Include copy of a blank voided check]

Please include copies of the following:

Copy of DEA Registration **and** State Pharmacy License
Copy of Tax Exemption Certificate(s)
Copy of Resale Certificate(s)

This section applies to all accounts with JOM Pharmaceutical Services, Inc. ("JOM")

This application is not a contract. Any sales resulting from this application will be subject to either the terms of any resulting contract between JOM and the Customer, or if no such contract exists to JOM's standard terms of sale posted at www.jom.com.

Signature

The person signing this form represents that the information provided herein in complete and accurate. Further, if this form is signed electronically then the person signing acknowledges that their signature below is considered an Electronic Signature and therefore valid in accordance with the provisions of United States Law (15 US Code, CHAPTER 96).

AUTHORIZED SIGNATURE: **Title:** **Date:**

Please send completed application to JOMCUSTOMERSERVICE@its.jnj.com or fax to 732-302-0425.

If your application is denied, you have the right to a written statement of the specific reasons for the denial. To obtain the statement, please contact JOMCUSTOMERSERVICE@its.jnj.com or fax your request to 732-302-0425 within 60 days from the date you are notified of our decision.