



Quantum Pharmacy Alliance  
APPLICATION FOR MEMBERSHIP

**GENERAL INFORMATION**

Corporate Name (if applicable): \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

(if multiple locations, please see next page for instructions)

Street Address: \_\_\_\_\_ PO Box: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Corporate Contact Person/Title: \_\_\_\_\_

DEA #: \_\_\_\_\_ HIN #: \_\_\_\_\_

Pharmacy License #: \_\_\_\_\_

Are you currently affiliated with another buying group?  NO  YES

Name(s): \_\_\_\_\_

**OWNERSHIP**

A. Type of ownership:

Non profit  For profit  Proprietorship  Partnership

Other: \_\_\_\_\_



PLEASE COMPLETE FOR ANY ADDITIONAL LOCATIONS

If your business has multiple sites, please provide a listing for each location to include:

1. Facility Name: \_\_\_\_\_
2. Address, City, State, Zip: \_\_\_\_\_
3. Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
4. DEA#: \_\_\_\_\_
5. E-mail Address: \_\_\_\_\_
6. Primary Contact Person: \_\_\_\_\_

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1. Facility Name: \_\_\_\_\_
2. Address, City, State, Zip: \_\_\_\_\_
3. Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
4. DEA#: \_\_\_\_\_
5. E-mail Address: \_\_\_\_\_
6. Primary Contact Person: \_\_\_\_\_

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1. Facility Name: \_\_\_\_\_
2. Address, City, State, Zip: \_\_\_\_\_
3. Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
4. DEA#: \_\_\_\_\_
5. E-mail Address: \_\_\_\_\_
6. Primary Contact Person: \_\_\_\_\_

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2. Address, City, State, Zip: \_\_\_\_\_
3. Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
4. DEA#: \_\_\_\_\_
5. E-mail Address: \_\_\_\_\_
6. Primary Contact Person: \_\_\_\_\_



Please check (✓) the primary type of practice setting your pharmacy(ies) operates in (okay to check more than one box):

1.  Hospital
2.  Nursing Home
3.  Physicians
4.  Home Health Service
5.  Clinics
6.  Surgical Center
7.  Rehabilitation Center
8.  Corrections
9.  Other (please specify)

**CONFIDENTIALITY**

This application does not constitute a contractual agreement between either party. However, this application is necessary to help determine if applicant is to meet our membership criteria. Under no circumstances will any of the above information be shared or reproduced by Quantum without the expressed written consent of a duly authorized person or your pharmacy.

Name (Printed): \_\_\_\_\_

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Upon approval of application, we will forward you a Membership Agreement.

**QUANTUM RESERVES THE RIGHT TO  
DETERMINE THE MEMBER'S ELIGIBILITY**

Please note, Quantum receives fees from many of its vendors. These fees are used to support the programs and services offered to our members.