



Akorn Enrollment Supplement Form for Practices with Multiple Locations

Telephone: (800) 932-5676 Fax: (800) 943-3694 • www.akorn.com

Use this form to enroll additional shipping locations for satellite offices

Complete this form (in addition to the Akorn Direct Enrollment Form) to enroll satellite locations in Akorn's Akorn Direct program. Fax the completed forms to (800) 943-3694.

APPLICATION SUPPLEMENT FOR (BUYER* NAME)

SECURE ACCOUNT NO. (IF KNOWN)

Use this section to add additional shipping addresses for satellite locations.

SHIPPING INFO

PHYSICIAN NAME

STATE MEDICAL LICENSE NO.†

DEA LICENSE NO.

EXPIRES

ADDRESS

CITY

STATE

ZIP

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PHONE

FAX

OFFICE HOURS (for delivery)

SHIPPING INFO

PHYSICIAN NAME

STATE MEDICAL LICENSE NO.†

DEA LICENSE NO.

EXPIRES

ADDRESS

CITY

STATE

ZIP

()

()

PHONE

FAX

OFFICE HOURS (for delivery)

SHIPPING INFO

PHYSICIAN NAME

STATE MEDICAL LICENSE NO.†

DEA LICENSE NO.

EXPIRES

ADDRESS

CITY

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PHONE

FAX

OFFICE HOURS (for delivery)

SHIPPING INFO

PHYSICIAN NAME

STATE MEDICAL LICENSE NO.†

DEA LICENSE NO.

EXPIRES

ADDRESS

CITY

STATE

ZIP

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PHONE

FAX

OFFICE HOURS (for delivery)

*The buyer is the individual or legal entity who enrolls in Akorn Direct and agrees to comply with all program Terms and Conditions as stated in the Enrollment Form. The buyer's duly authorized representative is an individual who possesses the legal authority to bind the buyer to abide by the Terms and Conditions specified on this Enrollment Form. Please see section 15 of the Terms and Conditions for more information.

† Entering your license number is for reference only. We may ask to obtain a copy of your state medical license. This information is for account set-up only.

SIGNATURE

BUYER (Please enter appropriate Legal Entity Name)

NAME

Buyer's Duly Authorized Representative (Please ensure appropriate individual signs this agreement; see section 15 for details)

NAME

TITLE

SIGNATURE

DATE

