[FACILITY LETTERHEAD]

[ADDRESS]

[CITY, STATE, ZIP]

[PHONE NUMBER]

[DATE]

Adapt Pharma Inc – Specialty Pharm Srvc

ATTN: Customer Service

15 Ingram Blvd.

LaVergne, TN 37086

I, [PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER NAME], am the responsible person for purchases made by [FACILITY NAME AND ADDRESS under my state license number [INDICATE STATE LICENSE #]) issued by the Commonwealth of Pennsylvania.

I will notify Adapt Pharma– Specialty Pharm Srvc immediately if my responsibility status and/or relationship with this facility is changed or terminated.

[PHYSICIAN’S SIGNATURE]