



RxPlus Pharmacies, Inc.  
Membership Application

Pharmacy Name \_\_\_\_\_  
*(If multiple locations, provide information for each location by attaching additional pages.)*  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone\_(\_\_\_\_\_) \_\_\_\_\_ Fax #\_(\_\_\_\_\_) \_\_\_\_\_  
Would you prefer to receive information by fax?      Yes              No

Ownership:      \_\_\_Sole Proprietor      \_\_\_Corporation      \_\_\_Other \_\_\_\_\_  
If incorporated, list officers; if not incorporated, list name(s) of owner(s):  
President \_\_\_\_\_  
Treasurer \_\_\_\_\_  
Secretary \_\_\_\_\_  
Shareholders \_\_\_\_\_

Professional Liability Information: (Attach current copy of declarations page.)  
Insurance Carrier \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Policy Coverage Amount (We require a minimum of \$1,000,000) \_\_\_\_\_

Is pharmacy 50% or more owned by a pharmacist? \_\_\_\_\_  
Name of pharmacy manager \_\_\_\_\_  
Primary Wholesaler \_\_\_\_\_ Secondary Wholesaler \_\_\_\_\_  
Primary Wholesaler Account Number \_\_\_\_\_  
NABP Number \_\_\_\_\_ DEA Number \_\_\_\_\_  
State License # \_\_\_\_\_ Store # \_\_\_\_\_  
Federal Tax ID # \_\_\_\_\_

Does pharmacy offer 24 hour prescription service?  
\_\_\_Yes      \_\_\_No  
Does pharmacy have areas set aside for patient consultation?  
\_\_\_Yes      \_\_\_No  
Does pharmacy offer prescription delivery service?  
\_\_\_Yes      \_\_\_No  
Does pharmacy have multiple language capabilities?  
\_\_\_Yes      \_\_\_No If yes,      \_\_\_Spanish      \_\_\_Other \_\_\_\_\_

Signature of Applicant \_\_\_\_\_ Title: \_\_\_\_\_  
Date: \_\_\_\_\_

(Only pharmacy owners or authorized managers may sign application.) The RxPlus Board of Directors reserves the right to review all applications for membership acceptance.