Manufacturer Membership Application Instructions

1. Complete each question on the application form. Please type or print clearly and make a copy for your records.
2. A one-time nonrefundable $1,000 application fee must accompany the completed forms. We accept all major credit cards or checks payable to HDA.
3. Make certain your application is signed by a senior company executive.
4. **You will be billed for annual membership dues once your application has been approved, pro-rated as applicable. Thereafter, dues are payable each year by January 31st.**
5. The completed application, with payment, should be returned to HDA at:

Email: Dues@hda.org

Fax: (202) 831-0969

Mail: HDA
Attn: Accounts Receivable
1275 Pennsylvania Avenue NW, Suite 600
Washington, DC 20004

For further information or assistance, please contact Lisa Kanfer, Vice President of Membership and Development at (202) 964-6066. Application processing may take up to 45 days.

Payments made to the Healthcare Distribution Alliance are not deductible as charitable contributions for federal income tax purposes. However, they may be deductible under other provisions of the Internal Revenue Code.

The Healthcare Distribution Alliance (HDA) represents primary pharmaceutical distributors — the vital link between the nation's pharmaceutical manufacturers and pharmacies, hospitals, long-term care facilities, clinics and others nationwide. Since 1876, HDA has helped members navigate regulations and innovations to get the right medicines to the right patients at the right time, safely and efficiently. The HDA Research Foundation, HDA's non-profit charitable foundation, serves the healthcare industry by providing research and education focused on priority healthcare supply chain issues.

Manufacturer Membership Application

GENERAL INFORMATION:

Applicant Company: _____

If division or subsidiary, name of Parent Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Website: _____

Please attach a list of addresses of parent company or other divisions/subsidiaries.

Date present business was established: _____

Company profile* (35–200 words): _____

_____

_____

_____

_____

_____

** The company profile will be included in the membership directory and event materials. HDA reserves the right to edit as necessary.*

KEY CONTACT:

Your key contact will be the recipient of all HDA membership information, including dues invoices.

Name: _____

Title: _____

Address: _____

City: _____

State: _____ Zip: _____

Email: _____

Phone: _____

Fax: _____

Providing the e-mail addresses of additional company contacts will ensure that they are able to access the HDA website (www.hda.org) as well as receive our weekly e-newsletter.

ADDITIONAL CONTACTS:

Name: _____

Title: _____

Email: _____

Name: _____

Title: _____

Email: _____

Name: _____

Title: _____

Email: _____

Name: _____

Title: _____

Email: _____

Name: _____

Title: _____

Email: _____

Name: _____

Title: _____

Email: _____

Why do you wish to become a member of HDA? ____

____

____

List examples of principal products or services: ____

____

____

DISTRIBUTION INFORMATION:

Facility Name: ______________________
Address: ______________________
City: ______________________
State: __________ Zip: __________
Contact: ______________________
Title: ______________________
Phone: __________ Fax: __________
Email: ______________________

This facility is:

- ❏ Owned and operated by your company
- ❏ A third party logistics company
- ❏ Owned by your company, but operated by a third party
- ❏ Other

Facility Name: ______________________
Address: ______________________
City: ______________________
State: __________ Zip: __________
Contact: ______________________
Title: ______________________
Phone: __________ Fax: __________
Email: ______________________

This facility is:

- ❏ Owned and operated by your company
- ❏ A third party logistics company
- ❏ Owned by your company, but operated by a third party
- ❏ Other

Facility Name: ______________________
Address: ______________________
City: ______________________
State: __________ Zip: __________
Contact: ______________________
Title: ______________________
Phone: __________ Fax: __________
Email: ______________________

This facility is:

- ❏ Owned and operated by your company
- ❏ A third party logistics company
- ❏ Owned by your company, but operated by a third party
- ❏ Other

Please list additional facilities on a separate sheet of paper.

BUSINESS INFORMATION:

Are there any litigation or regulatory actions pending against the applicant by federal, state or local governmental agencies or authorities? Yes No *(If yes, please attach separately, complete documentation of pending action)*

Do you currently have product sales? Yes No

What are your sales to HDA wholesalers for your most recent fiscal year?
(Please see list of HDA Distributor Members below)

Anda, Inc.

A-S Medication Solutions, LLC

Associated Pharmacies, Inc.

Auburn Pharmaceutical Company

BioCare, Inc.

Bloodworth Wholesale Drugs

BluPax Pharmaceuticals, LLC

Capital Wholesale Drug Co.

Cardinal Health, Inc.

Cencora, Inc.

Clint Pharmaceuticals, Inc.

Dakota Drug, Inc.

DMS Pharmaceutical Group, Inc.

Drogueria Betances, LLC

Health Coalition, Inc.

Henry Schein, Inc.

HyGen Pharmaceuticals, Inc.

Independent Pharmacy Distributor

KeySource

Louisiana Wholesale Drug Co. Inc.

McKesson Corporation

Medline Industries, Inc.

Morris & Dickson Co., L.L.C.

NDC Distributors

Numed Pharma

PBA Health

Pharmsource, LLC

Prescription Supply, Inc.

Prodigy Health

PRx Wholesale, LLC

R&S Northeast LLC

Real Value Rx dba Hospital Pharmaceutical Consulting

Richie Pharmacal Co., LLC

Smith Drug Company, Div. J M Smith Corporation

South Pointe Wholesale, Inc.

TopRx

Value Drug Company

VaxServe, A SANOFI PASTEUR COMPANY

TOTAL SALES (millions): _____

HDA'S MISSION:

Advocate for sound public policy that supports patient access to medicines and medical products through safe, efficient and effective distribution.

Lead the healthcare supply chain on policy issues, business practices and industry guidelines to inform and support member development of innovative solutions.

Convene and partner with public and private stakeholders to facilitate discussions on industry issues, provide education and support the sharing of leading practices.

❑ I have read the above mission statement of HDA and wish to promote those objectives.

Executive of Applicant Company: _____

Signature: _____

Title: _____ Date: _____

PAYMENT INFORMATION:

Total Application Fees: $1,000 **Form of Payment:** ❑ ACH ❑ MasterCard ❑ Visa ❑ AmEx ❑ Check

Send ACH Payments to:
Capital One Bank Acct# 1360464586 ABA/Routing# 065000090. Remittance to: acctdept@hda.org

Company Name: _____

Cardholder's Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ Exp. Date: _____ CVV: _____

Signature: _____

Make checks payable to HDA. Your form must be accompanied by payment in order to be processed. Payments to HDA are not deductible as charitable contributions for federal income tax purposes. However, they may be deductible under other provisions of the Internal Revenue Code. Tax ID #13-1088150.

HDA INTERNAL USE:

Company Name: _____

Company ID#: _____

Dues Year: _____