WEB: ParagardDirect.com
PHONE: 1-877-PARAGARD
FAX: 1-800-299-8332
EMAIL: customercare@paragarddirect.com

Letter of Affiliation (LOA)

The purpose of the Letter of Affiliation (LOA) is to establish the affiliation between the physician and entity or entities listed below. By completing this form, the physician will be responsible in all respects for the receipt and accountability of pharmaceutical products shipped to the entity listed on the form. The LOA is required for all new account set-ups and when updating a physician's license on an existing account.

New accounts: Sign and return completed form along with supporting documents and Business Application by email to accounts@paragarddirect.com or by fax to 1-469-365-8168.

Existing accounts: Sign and return completed form along with a copy of updated license by email to customercare@paragarddirect.com or by fax to 1-800-299-8332.

Physician License Information

Name: _____

License Number: _____

Entity Name and Address

Name of Entity: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone Number: _____

Optional–Shipping Addresses

Ship-to-Entity Name and Address

Name of Ship-to Entity: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone Number: _____

Ship-to-Entity Name and Address (Optional)

Name of Bill-to Entity: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone Number: _____

IMPORTANT: You MUST submit a copy of a valid license reflecting the license holder's name to Paragard Direct™

To Integrated Commercialization Solutions, LLC d/b/a Paragard Direct and its Affiliates:
The undersigned physician certifies that he/she (a) is affiliated with the entity and location identified above and any additional shipping locations listed above, (b) will be responsible in all respects for the receipt, recordkeeping, storage, handling and accountability of pharmaceutical products shipped to the entity at such location(s), and (c) will immediately notify you if either of the foregoing statements is no longer true.

This certification and authorization do not apply to shipment of controlled substances.

PHYSICIAN SIGNATURE REQUIRED

Physician Signature (must match name on license): _____

Physician (Print Name): _____

Date: _____