Safety Net Inventory Support Program

Application for Community Clinics and Health Centers

Please return the completed application <u>signed and dated</u> via email, mail, or fax, or to the contact information listed below. Applications that are missing required information will be returned.

Direct Relief USA, 27 S. La Patera Lane, Santa Barbara, CA 93117
questions@directrelief.org | (805) 964-4767phone | (805) 681-4838 fax

* *Indicates a required field*

Organizational Information	
Clinic Name*	
Address (Main Site) *	
Telephone*	
Fax*	
Website	
EIN - Must be a designated 501(c)(3)*	
HRSA ID (if applicable)	
Annual # Unduplicated Patients*	
Annual # Uninsured Patients*	
Annual # Encounters*	

Contact Information	
Primary Contact:* Pharmacist/Dispensary Manager (Name)	
Phone Number	
Email	
Medical Director(Name)*	
Phone Number	
Email	
CEO/Executive Director (Name)	
Phone Number	
Email	

Licenses	
Medical Director Medical License *	License# _____ Exp. Date: _____
Pharmacy/Medical Director DEA*	License# _____ Exp. Date: _____
Clinic/Health Center License	License# _____ Exp. Date: _____
Pharmacy/Dispensary License*	License# _____ Exp. Date: _____

Donation Program Agreement

DIRECT RELIEF INTERNATIONAL
MEDICAL PRODUCTS DONATION PROGRAM AGREEMENT

BACKGROUND AND TERMS OF USE FOR DONATIONS

Direct Relief International is a U.S.-based, non-profit medical relief and health assistance organization that is dedicated to serving the poor and victims of natural disasters and civil strife in the United States and throughout the world. Assistance is provided by distributing donated medical goods to charitable health care institutions and organizations. Direct Relief is non-sectarian and non-political, and requires that Partner facilities render services to all persons regardless of nationality, political affiliation, ethnic origin, religious belief or ability to pay.

Partner must assume full responsibility for the non-commercial use of the donated products and must ensure that no one is turned away due to the inability to pay for medical treatment.

PLEDGE

Partner agrees to distribute all medical goods, including, without limitation, pharmaceuticals, equipment and supplies received from Direct Relief strictly on the basis of need and without regard to race, religion, nationality, ethnic origin, or political affiliation, and in no case will Partner withhold these goods from needy persons because of their inability to pay for services. Partner agrees to assume full responsibility for the non-commercial use of this donation.

Partner further understand that the pharmaceuticals, equipment and supplies that are being donated are to be dispensed to uninsured low-income individuals who are patients of Partner's clinic. Partner will abide by all applicable Federal and State regulations in the dispensing of these products. These products will neither be sold nor traded, nor returned to the original manufacturer for credit. Partner understands that Partner's

clinic is responsible for the proper disposal of any unused pharmaceuticals, equipment and supplies and shall abide by all Federal or State regulations as may be applicable.

DISCLAIMER OF WARRANTIES AND LIABILITY BY DIRECT RELIEF INTERNATIONAL AND WAIVER BY PARTNER OF CLAIM TO INDEMNITY AND LEGAL DEFENSE

Partner understands and agrees that in providing donated pharmaceuticals, equipment and supplies; Direct Relief does not act as a seller or manufacturer for purposes of products liability law or for any other purpose.

DIRECT RELIEF IS NOT RESPONSIBLE FOR LOSS, INJURY OR DAMAGE CAUSED BY THE USE OF ANY MEDICINE, EQUIPMENT OR SUPPLIES OF ANY KIND THAT IS PROVIDED BY DIRECT RELIEF NO MATTER WHAT MANNER THEY ARE USED IN. INDIVIDUALS AND ORGANIZATIONS WHO USE OR DISPENSE OF THE PHARMACEUTICALS, EQUIPMENT OR SUPPLIES DONATED BY DIRECT RELIEF DO SO AT THEIR OWN RISK AND MAY SUFFER SERIOUS PERSONAL INJURY OR DEATH OR PROPERTY DAMAGE. DIRECT RELIEF MAKES AND HAS MADE NO WARRANTIES OR REPRESENTATIONS, EXPRESS OR IMPLIED, CONCERNING THE SUITABILITY OR SAFETY OF ANY OF THE PHARMACEUTICALS, , EQUIPMENT OR SUPPLIES, AND IT EXPRESSLY DISCLAIMS ALL SUCH WARRANTIES, INCLUDING WITHOUT LIMITATION, IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR PARTICULAR PURPOSE. DIRECT RELIEF IS A CHARITABLE ORGANIZATION AND DOES NOT HAVE THE EXPERTISE TO INSPECT, AND THEREFORE HAS NOT INSPECTED, ANY OF THE PHARMACEUTICALS, EQUIPMENT OR SUPPLIES THAT IT HAS DONATED. DIRECT RELIEF IS NOT RESPONSIBLE FOR DAMAGE, LOSS OR INJURY OF ANY KIND, INCLUDING CONSEQUENTIAL DAMAGES, RESULTING FROM THE USE OF ANY OF THE PHARMACEUTICALS, EQUIPMENT OR SUPPLIES THAT IT HAS DONATED.

Partner further agrees to indemnify, defend and hold Direct Relief, its employees and agents, harmless from any claims, liability, loss, damage or injury of any kind, including attorneys' fees and costs of litigation, directly or indirectly resulting from or associated with the products and/or equipment delivered herewith, and that Partner will not seek indemnity from Direct Relief for damages arising out of the condition or use of products or equipment delivered herewith. In no event shall Direct Relief be liable to Partner for loss of profits, indirect, special, exemplary, punitive or consequential damages.

This indemnity obligation by Partner shall be without regard to any negligent act or omission by Direct Relief, its employees, or agents.

Should either party be required to bring legal action to enforce the terms of this agreement, it is agreed that the prevailing party shall be entitled to an award of its costs and reasonable attorneys' fees.

In the event of a change in licensure status; including clinic or health center license, pharmacy license, dispensary license, or medical director license for the facility, Partner agrees to notify Direct Relief within 15 days of the change in status.

The parties each represent and warrant that they have the full power and actual authority to enter into this Agreement and to carry out all actions required of them by this Agreement. All persons executing this Agreement in representative capacities represent and warrant that they have full power and authority to bind their respective organizations.

Authorized Signatures

By signing below, I attest that the information provided with this application is true and accurate and understand and agree to the terms in the above agreement.

1. Medical Director / Chief Medical Officer

*Signature: _____ Date: _____

*Name (Please Print): _____

2. Chief Executive Officer / Executive Director

*Signature: _____ Date: _____

*Name (Please Print): _____