RX RETURNS CLIENT WORKSHEET

DATE: _____ REGION #: N/A

CLIENT NAME: _____ ACCT #: NEW
(as appears on DEA Certificate)

DBA NAME: _____ *Acct Type: 09 - UCSB research lab
(if different than DEA Name)

ADDRESS: _____ # OF LOCATIONS: 1

CITY: _____ STATE: _____ ZIP: _____

CONTACT #1 M: _____ TITLE: _____ PHONE: _____ EXT: _____

EMAIL ADDRESS: _____ FAX: _____

CONTACT #2 M: Derek Iverson TITLE: Health Physicist PHONE: 805-893-7256 EXT: _____

SEND REPORTS TO: Derek Iverson DIRECTOR M: N/A

ADDRESS: 565 Mesa Rd DIR PHONE: N/A EXT: _____

CITY: Santa Barbara STATE: CA ZIP: 93106

OWNERSHIP AFFILIATION: N/A BUYING GROUP (GPO): N/A

INSURANCE RECONCILIATION PROVIDER: N/A

PSAO: N/A PHARMACY SWITCH: N/A

*Types – 01-Inpatient, 02-Outpatient, 03-Ancillary, 04-Institutional, 05 Retail, 06-Physician's Office, 07-Veterinarian, 08-Long Term Care, 09-Other (explain), 10-Wholesaler, 11-Manufacturer

DEA #: _____ EXP DATE: _____ STATE LICENSE #: N/A EXP DATE: N/A

Accounts Payable/Statement Information:

PO NEEDED?: YES: _____ NO: X

COMPANY NAME: University of California Santa Barbara PO #: N/A EXP DATE: N/A

A/P CONTACT: Ann Boochangkool A/P CONTACT EMAIL: ann.boochangkool@fm.ucsb.edu

ADDRESS: 565 Mesa Rd CITY/ST/ZIP: Santa Barbara / CA / 93106

CONTACT PHONE: 805-893-2539 EXT: _____ FAX #: 805-893-7176

WOULD CLIENT LIKE TO BE OFFERED PAYMENT BY CREDIT CARD BEFORE INVOICING?: YES: X NO: _____

Wholesaler Information:

WHOLESALER: _____ ACCT #: _____

ADDRESS: _____ CONTACT: _____

CITY/ST/ZIP: _____ PHONE: _____ EXT: _____

Miscellaneous/Other Information: _____ FAX #: _____

EMAIL COMPLETED FORM TO: Gary Vivanco

EMAIL ADDRESS: gary.vivanco@inmar.com