PLEASE EMAIL COMPLETED FORMS TO: CE-NationalAccounts@Evolus.com

CERTIFICATION FORM

HEALTHCARE PRACTITIONER LICENSE AND MEDICAL PRACTICE ADDRESS CERTIFICATION

I,_____**(print name)**, do hereby covenant, represent and warrant to Evolus, Inc. ("Evolus") that:

- I shall at all times operate in compliance with all applicable federal, state and local laws and regulations, as well all applicable medical and ethical standards;
- I shall use and administer, and cause my employees, agents and contractors to use and administer, all Evolus products in accordance with all applicable federal, state and local laws and regulations;
- All of my employees, agents and contractors administering Evolus products shall be trained in proper administration techniques;
- I shall purchase Evolus products only for direct sale to patients, and will not re-sell products to other healthcare professionals or any other third parties without the prior written consent of Evolus;
- I am appropriately licensed under applicable state law to prescribe and administer Evolus products;
- I shall ensure that all employees, contractors and agents of my practice who administer Evolus products hold a valid medical license in the appropriate state(s) and that they shall administer the products under my medical supervision as required by applicable law;
- I shall only purchase Evolus products from Evolus or its authorized distributors;
- I shall not export any Evolus products from the United States or import any Evolus products into the United States;
- I will not seek federal, state or local healthcare reimbursement (e.g., Medicare, Medicaid, Tricare, etc.) for any Evolus product;
- I will, as soon as reasonably practicable, notify Evolus of any known or suspected problem, defect or anomaly with any Evolus product; and
- I shall administer Evolus products only at a healthcare facility that operates in compliance with all applicable laws and regulations.

I currently have a valid, licensed healthcare practice, or am a practicing member of a healthcare practice, located at:

please list full shipping address and valid license

_____

_____

_____

Print Address(es) above, continue on page 2

I further agree that if the status of my healthcare practitioner license, or if the state qualified injectors under my supervision changes, or my primary practice address changes, I will notify Evolus, Inc. immediately and will go through the procedures required by Evolus, Inc. to recertify my account. I agree that no product will be shipped to any address until this recertification process is complete.

Any modifications to this form will be rejected.

_____ _____

SIGNATURE DATE

_____

PRINT NAME LICENSE/NPI NUMBER

Additional Addresses: