Letter of Affiliation

c/o Integrated Commercialization Solutions, LLC.
5025 Plano Parkway, Carrollton, TX 75010
Telephone: (877) 852-8542
Fax: (877) 852-8545

Physician License Information:

Physician Name: _____

Licensce No: _____

License Exp: _____

Entity Name and Address:

Name of Entity: _____

Address: _____

_____

_____

Contact Person: _____

Additional shipping addresses may be listed below.

To: Integrated Commercialization Solutions, Inc. on behalf of Serb.

The undersigned physician certifies that he/she (a) is affiliated with the entity and location identified above and any additional shipping locations listed below, (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 does not apply to shipment of controlled substances.

(Optional) I authorize the following representatives to accept and be responsible for pharmaceuticals delivered to the shipping address(es): Print Name(s): _____

PHYSICIAN SIGNATURE REQUIRED: (must match name on license)

Signature: _____

Print Name: _____ **Date:** _____

NOTE: **You MUST submit:**

- A copy of a valid license reflecting the license holder's name

Additional Shipping Addresses (optional):

Shipping Address:

Name of Location: (if different from above) _____

Address: _____

Contact Person: _____

Phone No.: _____

Shipping Address:

Name of Location: (if different from above)

Address: _____

Contact Person: _____

Phone No.: _____