Additional Branch Locations

Branch Name:______________________ Store Contact:______________________
Branch Address:______________________ City:______________________ State:_______ ZIP Code:____________
Phone:________________ Fax:______________________ Email:______________________
Medicare#: ____________ Medicaid#:______________________ Federal Tax ID#:______________________

Branch Name:______________________ Store Contact:______________________
Branch Address:______________________ City:______________________ State:_______ ZIP Code:____________
Phone:________________ Fax:______________________ Email:______________________
Medicare#: ____________ Medicaid#:______________________ Federal Tax ID#:______________________

Branch Name:______________________ Store Contact:______________________
Branch Address:______________________ City:______________________ State:_______ ZIP Code:____________
Phone:________________ Fax:______________________ Email:______________________
Medicare#: ____________ Medicaid#:______________________ Federal Tax ID#:______________________

Branch Name:______________________ Store Contact:______________________
Branch Address:______________________ City:______________________ State:_______ ZIP Code:____________
Phone:________________ Fax:______________________ Email:______________________
Medicare#: ____________ Medicaid#:______________________ Federal Tax ID#:______________________

Branch Name:______________________ Store Contact:______________________
Branch Address:______________________ City:______________________ State:_______ ZIP Code:____________
Phone:________________ Fax:______________________ Email:______________________
Medicare#: ____________ Medicaid#:______________________ Federal Tax ID#:______________________

Branch Name:______________________ Store Contact:______________________
Branch Address:______________________ City:______________________ State:_______ ZIP Code:____________
Phone:________________ Fax:______________________ Email:______________________
Medicare#: ____________ Medicaid#:______________________ Federal Tax ID#:______________________

Branch Name:______________________ Store Contact:______________________
Branch Address:______________________ City:______________________ State:_______ ZIP Code:____________
Phone:________________ Fax:______________________ Email:______________________
Medicare#: ____________ Medicaid#:______________________ Federal Tax ID#:______________________

Please include additional branch locations on a separate sheet

Member Application

(Office use only)

Member #:______________Dues:____________Member Service Rep:__________________Start Date:________

I wish to join the following VGM Group company(ies): O VGM O U.S. Rehab O Home Infusion O AHIA

Please print clearly and complete all fields:

Legal Company Name:_____________________________________DBA:_________________________________

Health System/Hospital: O Yes O No

Mailing Address:____________________________ City:_______________State:_____ZIP code: ____________

Phone:____________________________ Fax:____

Toll-free Phone:_____________________________Business Hours:_____________________________________

Owner's Name:____ Email:___________________________

Owner's Name:____ Email:___________________________

Store Contact (if different than owner):______________________________ Email:___________________________

Key Contact:____ Email:___________________________

Purchasing Contact:____ Email:___________________________

Federal Tax ID#:________________________________Medicare#:_______________________________________

NPI#:______________________________________Medicaid#:_______________________________________

Bond Renewal Date:______________

If different than above, please include the following:

Shipping Address:____

Billing Address:____

Remit Address:____

Do you have any branch stores? O Yes O No If yes, total number of branch stores:_________________

****Please include additional branch locations on back page.***

Number of employees:___________Years in business:____________ Est. annual revenue:_________________

List your top 5 product vendors and approximate annual volume with each:

1.______________________Annual volume:_______________4.____________________ Annual volume:______________

2.______________________ Annual volume:_______________5.____________________ Annual volume:______________

3.______________________ Annual volume:_______________

Accounts payable contact person at your company:____

Do you currently belong to any group purchasing organization (GPO)? O Yes O No

If yes, what organization?____

Please list all memberships in state associations:____

Website address:____

Liability insurance carrier?____________________________________ Renewal Date:______________________

Currect Limits (optional):____

Accreditation and certification

Please specify your professional accreditation organization:

O ACHC O CHAPS O HQAA O JCAHO O Other:____

Credentialed employees: *(check all that apply)*

O CEAC O ATP O SMS O RRT O CRTS O PSGT O RPH O RN O LPN

Patient Travel Coordinator:______________________ Phone (direct line):___________________________

How did you hear about VGM? Please be specific:____

____

____

Reasons for joining:____

____

____

____

What products or services do you provide? *(Please check all that apply)*

O Wheelchairs
O Custom rehab
O Ramps (rental)
O Ramps (built)
O Stair lifts
O Porch lifts
O Ceiling lifts
O Elevators
O Grab bars (install)
O Bath remodels
O Kitchen remodels
O ECUs (environmental control units)
O Wheelchair/scooter lifts
O Vehicle modifications
O Bariatric supplies
O Infusion services
O Beds
O Low air loss therapy
O Patient supports
O Patient lifts
O Enteral nutrition
O CPMs
O Phototherapy
O Electrotherapy
O Diabetic supplies
O Diabetic shoes
O Retail pharmacy
O Lymphedema pumps
O Ostomy/colostomy
O Wound care
O Incontinence supplies
O Conversion vans
O Oxygen concentrators
O Liquid oxygen
O Gaseous oxygen
O Transfilling concentrators
O Portable oxygen concentrators (POC)
O Respiratory meds/nebs
O CPAP/Bi-PAP
O Apnea monitors (infant)
O Volume ventilators
O Sleep labs
O Unattended sleep testing
O Orthotics/prosthetics
O IV therapy
O Home health services
O Breast pumps

I understand that my dues will be_______per month and that ***I must stay current (30 days)*** or will be subject to cancellation.

You warrant the information on or relating to this application is accurate, true and complete, and you will notify us of any material change to such information. We comply with Section 326 of the USA Patriot Act, which mandates that we verify certain information about you while processing your account application. You hereby authorize any bank, financial institution or trade reference listed herein to release usual and customary business or personal credit information to VGM. You also authorize us to offset any sums due from any of our affiliated companies, including but not limited to HOMELINK®, against any unpaid sums you owe us, our affiliated companies, without notice. You hereby waive any and all claims for payment of any offset made and also release HOMELINK from any and all claims or liability for said payment. You understand that we enter into contracts with certain vendors to obtain discounted pricing for VGM members, and that such vendors may pay a fee to VGM of up to three percent of the price of goods you purchase from the vendor. A copy of this signed authorization shall be deemed an original for all purposes. VGM reserves the right to refuse any applicant.

By signing up for VGM membership, you are opting in to receive our email messages, including industry articles, HME blog columns, legislative updates and savings opportunities. Opt out options are available at the footer of every email message.

Owner's Signature:____Date:___________________________

VGM Associate: ____Date:___________________________