



MEDICAL EQUIPMENT/SUPPLIES SUPPLEMENT

(Attach product listing for all products sold, leased or rented)

Applicant: _____

Business Address: _____

Applicant is: Individual Partnership Corporation Non-Profit Other (describe) _____

Contact person for inspection, etc.: _____

Website Address: _____

Telephone: _____ Fax: _____ Email: _____

Number of years in operation: _____ States registered/licensed in: _____

1. Does applicant **SELL** any medical supplies and/or equipment? Yes No Total Annual Sale: \$ _____

2. Does applicant **RENT** or **LEASE** any medical supplies and/or equipment? Yes No Total Rental/Lease: \$ _____

3. Does applicant **REPAIR** or **DO MAINTENANCE** on any medical supplies or equipment? Yes No

Total annual repair/maintenance receipts: \$ _____ Total annual repair/maintenance Payroll: \$ _____

(If you have answered "NO" to both 1 and 2, please skip this section. If you answered "YES" to either 1 or 2, please complete the remainder of this section)

Category I. **Expendable Items** – Intended for one time usage and disposed:

Bandages, cotton balls, swabs, surgical gloves, syringes, hypodermic needles, disposable linens, incontinence and catheter supplies, bed pans, ostomy, diabetic and wound care supplies, hot & cold compresses, bandaging material and antiseptics, knee & ankle wraps, other one time use items not listed.

Annual Sales: \$ _____

Category II. **Non-Expendable Items** – Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to:

Hospital beds, safety and bars, portable toilets, shower seats, walkers, wheelchairs, scooters, canes, crutches, patient lifts and hoists, IV stands, breast pumps, blood pressure cuffs, bed wedges, seat cushions, pillows, bedside trays, etc.

Annual Sales: \$ _____ Rental/Lease: \$ _____

Category III. **Diagnostic or Treatment Devices** – This category includes:

Apnea (sleep) monitors, CPAP, Parental (TPN), Eternal Therapy (EN), feeding pumps, TENS units, nebulizers, infusion therapy supplies, oxygen and other medical gases, blood pressure gauges, portable EKG machines, etc.

Annual Sales: \$ _____ Receipts: \$ _____

Category IV. **Life Sustaining or Critical Life Monitoring Equipment or Devices** – This category includes dialysis or heart/lung machines, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction/failure or improper function of which could result in death or serious deterioration in health conditions. (Please attach list of category IV equipment or devices)

Annual Sales: \$ _____ Rental/Lease: \$ _____

4. Does the applicant manufacture any products: Yes No

5. Is the applicant named as an additional applicant – vendor on the manufacturer's/supplier policy for any/all products: (Note: required for any category IV products) Yes No

If yes, please explain _____

6. Does the applicant obtain certificates of insurance from their products suppliers? Yes No

7. Do you or have you ever distributed or directly imported products from a foreign manufacturer? Yes No
 If yes, please explain _____
 Does the foreign manufacturer have a U.S. location? Yes No
8. Do you modify any product in any way from its intended use? Yes No
 If yes, please explain _____
9. Do you do any repackaging or relabeling of items obtained from suppliers? Yes No
 If yes, please explain _____
10. Does the manufacturer's label remain on the equipment? Yes No
11. Do you maintain a written quality control program? Yes No
12. Do you perform preventive maintenance on all equipment according to a written schedule? Yes No
13. Is all equipment checked and their condition documented prior to their release? Yes No
14. Are serial numbers of the finished product shown on shipment invoices and complete records kept of an inventory shipment? Yes No
15. Do you use the services of an EPA approved contractor for the disposal of hazardous waste materials?
 If yes, what kind of materials? _____ Yes No
16. Does applicant have any exposure to nuclear or radioactive materials? Yes No
17. On oxygen, oxygen related equipment, life sustaining or critical life monitoring equipment or devices, describe the 24 hour service, 365-day/year programs that exists:

18. Do you distribute oxygen cylinders? Yes No
 If yes, are they pre-filled or do you fill them at your premises? _____
19. Do you follow F.D.A. and D.O.T. regulations for the sterilization and transportation of oxygen? Yes No
20. Have any products that you distribute ever been recalled? Yes No
21. Does manufacturer or supplier that applicant uses provide written instructions and warranties for the use of the product? Yes No

MAINTENANCE AND/OR REPAIR OF EQUIPMENT

1. Do you **SELL** other supplier's used equipment? Yes No
 Revenue derived from this operation \$ _____
2. Do you **REPAIR** other supplier's used equipment? Yes No
 Revenue derived from this operation \$ _____
3. Please list all types of equipment you **SELL** or **REPAIR**:

4. Are manufacturer's recommendations followed for all repair of equipment? Yes No
5. Do you subcontract labor for any installation, services or repair? Yes No
6. Are certificates of insurance obtained from those subcontractors that provide installation, service or repair? Yes No