

Authorization for Purchase of Medical Devices

1	CUSTOMER, FACILITY, AND SHIPPING INFORMATION
<i>Please Print or Type:</i> Company Name: _____ Account # _____ Primary Contact/Title: _____ E-mail: _____ Authorized Purchaser(s): _____, _____, _____ Address: _____, City: _____, State: _____, Zip: _____ Company Shipping Address: _____ City: _____ State: _____ Zip: _____ Telephone: _____ Alternate Telephone: _____ *If more than one shipping address is authorized, attach a signed list. Approval applies only to verified addresses.	
2	PRODUCT CATEGORY AND CREDENTIAL INFORMATION
I, the undersigned, am a licensed practitioner or authorized representative for the above-named facility and am legally authorized under the laws applicable to the purchaser and shipping destination to order the medical devices selected below. I authorize shipment only to the verified address(es) listed on this form and am submitting copies of all applicable professional licenses, facility or agency credentials, permits, certifications, or patient-specific prescriptions/orders. ____ Broad Medical Device Authorization (Examples: IV catheters and sets, needles and sharps, syringes, ET tubes, LMAs, rescue airways, and related supplies). <i>Approval is limited to products supported by applicable law and the submitted credentials; this selection does not guarantee approval of every medical device.</i> ____ Category-Specific Medical Device Authorization (Examples: suction units, pulse oximeters, bag valve masks, ventilators, hemostatic dressings, and related supplies). <i>Select each requested category on page 2 of this form.</i> Professional/Facility License or Credential #: _____ Type: _____ Issuing State: _____ Expiration: _____	
3	STATEMENT OF AUTHORITY AND SIGNATURE
I certify that: (i) I am the (check one): ____ Medical Director ____ Licensed Practitioner ____ Authorized Facility/Agency Representative ____ Other: _____; (ii) I am legally authorized to order the selected products for the facility and shipping destination identified above; (iii) the information and attached credentials are current, complete, and accurate; (iv) the products will be purchased for legitimate professional, facility, or agency use and used only by appropriately trained and supervised personnel; (v) the products will not be resold, transferred, or provided to an unauthorized person or entity; and (vi) the products will be stored, handled, and used in accordance with applicable law, labeling, and professional requirements. I understand that WPSG may verify credentials, request additional documentation, restrict product categories, suspend authorization, or decline an order. Licensed Practitioner/Authorized Representative Signature: _____ Date: _____ Print Name: _____ Print Title: _____ Instructions: <i>This Authorization is valid only when accompanied by copies of all credentials, permits, certifications, or prescriptions/orders applicable to the products selected in Part 2. Authorization expires on the earliest applicable credential expiration date or two years after submission, unless WPSG establishes an earlier date. A new Authorization and supporting documentation must be submitted upon expiration or whenever there is a change in licensed practitioner, medical oversight, facility status, authorized purchaser, approved shipping address, or applicable credential. The customer must promptly notify WPSG of any such change.</i>	

Please complete this form and submit copies of all applicable credentials, permits, certifications, or prescriptions/orders to Witmer Public Safety Group, Inc. by email to sales@wpsginc.com or by mail to 101 Independence Way, Coatesville, PA 19320, ATTENTION: Sales at theEMSstore. Submission does not guarantee approval.

4	Product Categories
	1. ☐ IV Catheters 2. ☐ IV Admin Sets & Supplies 3. ☐ Syringes 4. ☐ Sharps & Needles 5. ☐ Ventilator & Supplies 6. ☐ CPAP & Supplies 7. ☐ Rescue Airways 8. ☐ ET Tubes & Supplies 9. ☐ Video Laryngoscope 10. ☐ Suction Units & Supplies 11. ☐ Hemostatic agents 12. ☐ Oxygen Supplies 13. ☐ Pulse Oximetry 14. ☐ Cardiac Supplies 15. ☐ Trauma Supplies Licensed Practitioner/Authorized Representative Signature: _____ Date: _____