

THE HUB

Partner Onboarding Form

Make a copy and add the client (partner) name to the title.

PARTNER DETAILS

Organization Information

Organization Name:

Address:

City: State:

Zip: Phone Number:

Sales Rep who referred you:

Sales Org Name:

Sales Rep Email:

USERS

Check the box next to the user who is your Main Business Point of Contact — our main contact for clinic / system updates.

User 1 ☐ Main Business Point of Contact

Full Name:

Email Address: Phone Number:

User 2 ☐ Main Business Point of Contact

Full Name:

Email Address: Phone Number:

User 3 ☐ Main Business Point of Contact

Full Name:

Email Address: Phone Number:

**Continue as needed for additional users.*

FACILITIES — SHIP TO (BULK)

Facility 1

Name:			
Address:			
City:		State:	
Zip:		Email (For notifications):	
Medical License Number:		License Expiry Date:	
NPI:			

****MUST attach one of the following for verification: a copy of your medical license, a screenshot of your NPI lookup, or a screenshot of your state medical license lookup.**

Facility 2

Name:			
Address:			
City:		State:	
Zip:		Email (For notifications):	
Medical License Number:		License Expiry Date:	
NPI:			

****MUST attach one of the following for verification: a copy of your medical license, a screenshot of your NPI lookup, or a screenshot of your state medical license lookup.**

Facility 3

Name:			
Address:			
City:		State:	
Zip:		Email (For notifications):	
Medical License Number:		License Expiry Date:	
NPI:			

****MUST attach one of the following for verification: a copy of your medical license, a screenshot of your NPI lookup, or a screenshot of your state medical license lookup.**

***Continue as needed for additional facilities, or send a CSV if 20+.**

PAYMENT

***Invoice — only for 500+ orders.*

Invoice

Billing Email:			
Address:		Suite:	
City:		State:	
Zip:		Phone:	

FOR PATIENT-SPECIFIC ORDERING

Prescriber First and Last Name:			
Address:			
Phone:		Email Address:	
NPI:		License #:	

****** MUST ATTACH IMAGE OF PRESCRIBER'S SIGNATURE ******

****** ONLY PRESCRIBERS CAN ORDER GLPs ******

SALES REP FACILITY ACCESS

If any Sales Rep needs facility access, please provide the following. All of this information is required. One Sales Rep may be assigned to multiple facilities — list each facility separately so we can clearly identify which facilities the rep can access.

Sales Rep Name:	Midwest Medical, LLC	Sales Rep's Email:	tcmidwestoh@gmail.com
Facility Name:			
Facility Address:			
Facility NPI Number:			
License Number:		License Expiration Date:	

****MUST attach the license document.**

**Continue as needed if the Sales Rep needs access to additional facilities.*

SUBMIT