

Introducing
ONCOLOGY ASSOCIATES
Physician Network Services
a division of RC Medical, Inc.



Oncology Associates (OA) is proud to announce its exclusive distributor arrangement with FloridaInfusion (FIS)

Oncology Associates is a group purchasing organization designed to offer the discount pricing benefits of group purchasing to private practice Physicians throughout the United States. Our team of experienced clinical and sales personnel have contracted with major pharmaceutical and medical supply manufacturers to allow us to offer a diverse portfolio of products at favorable prices to members of **Oncology Associates** GPO.

How The Oncology Associates Group Purchasing Program Works...

Like most group purchasing programs, ours is simple. In order to purchase goods through the **Oncology Associates** program and achieve the negotiated pricing you must adhere to the following simple terms:

- Sign a standard membership agreement.
- Purchase products from manufacturers/distributors under contract with **Oncology Associates**.
- Identify yourself as an **Oncology Associate** member with each purchase.
- Abide by the standard sale and payment terms/conditions of the wholesaler or distributor.

Oncology Associates (OA) is proud to announce its exclusive distributor arrangement with **FloridaInfusion** (FIS). In an effort to afford members the best of both the GPO and wholesale distributor worlds, OA and FIS have agreed to form this alliance to better meet both organizations customer's needs.

For more information contact your Account Manager or Customer Service at 1-800-624-0152.

ONCOLOGY ASSOCIATES MEMBERSHIP AGREEMENT

ONCOLOGY ASSOCIATES MEMBERSHIP AGREEMENT

The Agreement is entered into this _____ day of _____ 200__ by and between Oncology Associates, a division of RC Medical, Inc., an Ohio Corporation (hereinafter referred to as OA) with its principal place of business located at 6120 Parkland Blvd., Suite 304 Mayfield Heights, Ohio 44124 and _____ (hereinafter referred to as Participant), with its principal place of business located at:

WHEREAS, OA is a group purchasing organization specializing in the negotiating and management of discount contracts of certain medical and pharmaceutical products: and WHEREAS, Participant is a licensed, private practice medical physician or physician group who wishes to purchase certain products and services through the OA group purchasing organization.

NOW, THEREFORE, in consideration of the mutual covenants contained in this Agreement, the parties agree as follows:

TERM. The term of this Agreement shall be one (1) year, commencing the _____ day of _____ 200__ and terminating on the _____ day of _____ 200__ (“termination date”). This Agreement will automatically renew annually for one (1) year periods unless either party notifies the other within thirty (30) days of the expiration of the Agreement, of its intent not to enter into another term of the Agreement.

TERMINATION. This Agreement may be canceled without cause by either party upon thirty (30) days written notice to the other party, at which time this Agreement shall have no further force or effect.

QUALIFICATION. OA represents and warrants that it and its employees providing services here-under have all qualifications, certifications, and licenses required pursuant to federal, state and/or local law, or pursuant to any other governmental regulation, for the full performance of its duties hereunder. Participant represents and warrants that it and its employees purchasing goods or services hereunder have all qualifications, certifications and licenses required pursuant to federal, state and/or local law, or pursuant to any other governmental regulation, for the performance of its duties hereunder.

RESPONSIBILITIES OF ONCOLOGY ASSOCIATES. OA is a group purchasing organization (GPO) and is responsible for negotiating the pricing and terms, as well as managing the contract(s) for products and services that are to be purchased by members of the OA GPO. OA does not take possession of the goods or perform the services offered by the OA GPO. OA is not responsible for any actions of the wholesaler, distributor, or manufacturer. OA is not responsible for actions resulting from the use of any goods or services purchased and used by the Participant, this includes any damages or liability that results from the Participant’s use of any goods or services purchased through OA GPO contracts. OA is not responsible for any damages or liabilities that result from the use of any and all goods and services purchased through the OA GPO contracts, including, without limitation, any defects or damages to the goods and services, delays in delivery and/or any other act or omission by the wholesaler, distributor, manufacturer, or any other party.

RESPONSIBILITIES OF THE PARTICIPANT. Participant agrees to purchase regularly, substantially all of its needed goods and services for the specific goods and services available through the OA contracts and recognize OA as its primary GPO for such goods and services. Participant will identify itself as an OA GPO member when ordering such goods and services from the wholesaler, distributor and/or manufacturer. Participant is solely responsible for payment to the wholesaler, distributor and/or manufacturer for any and all goods and services it purchases pursuant to an OA contract and understands that OA is in no way responsible for any payments for goods and services owed to any party by the Participant.

CONFIDENTIALITY. All contract, prices and terms offered through the OA GPO are confidential and proprietary information considered property of OA. Participant may not disclose such pricing to any other third party, including other group purchasing organizations, wholesalers, distributors, or manufacturers without the prior written consent of OA, except when Participant is required to by law.

PURCHASES FOR "OWN USE." Participant acknowledges that all goods and services purchased through the OA GPO contracts are being purchased for use solely by the Participant. Participant also acknowledges that it is not engaged in retail sales and will not directly or indirectly cause any goods or services purchased through the OA GPO contracts to be sold or used by any third party outside of the class pursuant to which it was originally purchased. Participant further warrants and represents that it shall not buy, distribute, sell, transfer, or use any pharmaceutical(s) purchased through an OA GPO contract in any manner that is contrary to the requirements of any provision of the prescription Drug Market Act of 1987. It is the responsibility of the Participant to identify to OA the class of trade to which it belongs (i.e. physicians group) and agrees to hold harmless OA and/or its affiliated corporations for any costs, expenses, losses or damages incurred as a result of Participant's designation of an inappropriate class of trade. OA may at any time request documentation/information regarding the Participant's class of trade and failure to do so may result in termination of the OA GPO membership agreement.

PRICE AGREEMENT/SCHEDULES. The OA contract price schedule will be provided to all Participants upon execution of this Agreement. Updates and additions to the OA price schedule will be provided to participants as such changes/additions occur.

COMPENSATION TO ONCOLOGY ASSOCIATES. OA may earn compensation for the services it provides. Such services may include but are not limited to the following: contract development and price negotiations; marketing/sales; and management services. OA may receive an administrative management fee paid to OA by vendors in contract with the OA GPO. Compensation may be based on a fixed amount or it may be in the form of a percentage of the value of purchases made by members of the OA GPO.

NOTICES. All notices, demands or other writings shall be deemed sufficiently given if personally delivered or deposited in the United States mail in a properly stamped envelope, certified mail, mail return receipt requested, addressed to the party to whom it is given at the addresses set forth in the first paragraph of the Agreement. Each party shall promptly notify the other in writing of any change of address.

AMENDMENT AND WAIVER. This instrument contains the entire agreement of the parties and supersedes any and all prior oral and/or written agreements between the parties. No amendment, modification or discharge of this Agreement, and no waiver hereunder shall be valid or binding unless set forth in writing and duly executed by the party against whom enforcement of the amendment, waiver, modification or discharge is sought. The waiver by either party of a breach of any provision of this Agreement shall not operate as, or be construed to be a waiver of any subsequent breach of any other term or provision of this Agreement.

GOVERNING LAW. This Agreement shall be governed by and interpreted in accordance with the laws of the state of Ohio. Venue and jurisdiction for any litigation between parties shall lie in Ohio.

Participant:

Business or Company Name:

Name (printed)

Title

Signature

Date

Oncology Associates, a division of RC Medical, Inc.

Date

GROUP DECLARATION FORM

(Member/Facility) _____ declares **Oncology Associates** as its Exclusive and sole group purchasing organization for the purposes of all **Amgen, Baxter, Bedford Laboratories, Eisai, Ortho Biotech, and Pharmion**, contract awards. We no longer wish to utilize our current contracts previously awarded to any former group purchasing organization to which we may have belonged.

** PLEASE INDICATE ALL PHYSICIANS AND DEA # FOR EACH FACILITY LISTED

_____ Physician Name	_____ DEA #
_____ Physician Name	_____ DEA #
_____ Physician Name	_____ DEA #
_____ Physician Name	_____ DEA #

ELIGIBILITY: By signing below, Participating Member certifies that the below information is correct, and agrees that any Oncology Associates Contracted Manufacturer’s (as listed above) Product purchased under any agreement shall be for its “own use,” as defined by the United States Supreme Court in its opinions report as Abbott Laboratories et al. V. Portland Retail Druggist Association, Inc., 425 U.S. 1 (1976), and Jefferson County Pharmaceutical Association, Inc., V. Abbott Laboratories, et al., 103 S. Ct. 1011 (1983).

The undersigned is a duly authorized representative of the Participating Member and hereby executes this Exhibit as of the date below written.

_____ Authorized Signature	_____ DEA #
_____ Print Name & Title	_____ Date
_____ Address	_____ City, State & Zip Code

Is the Participating Member wholly owned by the GPO or by an entity that wholly owns the GPO?
Circle One: Yes No

Oncology Associates

Notice of Participation

Physician Practice Group _____ # of Physicians _____

Participant's Name _____

Address _____

City/State _____

DEA #(s) _____

Telephone _____ Fax _____ Email _____

Contact Name & Title _____

Telephone _____ Fax _____ Email _____

Oncology Associates
6120 Parkland Blvd. • Suite 304, Mayfield Heights, OH 44124

(888) 732-7352 phone
(800) 624-0156 fax

Date

X

Participant Signature (Required)

Oncology Associates

Contract #

Manufacturer

Wyeth-Ayerst Pharmaceutical/Genetics Institute

We have recently received notification from the _____ buying group that you have terminated your membership with them. Your organization selected this group in response to the Exclusive Group policy initiated by Wyeth-Ayerst, it will be necessary for you to make another sole group selection. Please complete the Exclusive Group Declaration Form below and return it as soon as possible.

Exclusive Group Declaration Form

Wyeth-Ayerst has an Exclusive Group Membership policy for each business for which we contract. This policy requires that one group be selected for a sole affiliation under which all awarded contracted products will be priced. That group will be notified of your selection. Please complete the information requested below and return it promptly to : _____ at FAX number: 800-624-0156

Customer Name _____ W-A Customer _____

Address _____ DEA Number _____

Address _____

City _____ State _____ Zip Code _____

()

Phone _____

**Wyeth-Ayerst Pharmaceutical
Contract Development & Administration
P.O. Box 8299
Philadelphia, PA 19101-8299**

I fully understand the information stated above and have the authority to make the designated selection for the facility so listed.

Signature _____ Date _____

Name (Please Print) _____ Title _____

Oncology Associates _____

Group Purchasing Organization Selection _____ New Group Effective Date _____

If you have any questions or need additional assistance, please contact your
W-A Customer Service Representative @ 1-800-666-7248 or G.I. @ 1-888-440-8100.

INTERNAL USE ONLY:

_____	_____	_____
Group Number	Completed On	Initials of W-A Staff

Amgen Declaration Form

Physician Name _____

Practice Name _____

Address _____ Suite # _____

City _____, State _____, Zip _____ DEA #: _____

Dear OA Member,

Oncology Associates has recently entered into a Group Purchasing Organization Agreement with Amgen (“Oncology Associates/Amgen GPO Agreement”) for the purchase of Amgen products. In order to participate under the Oncology Associates/Amgen GPO Agreement, please certify your request to purchase Amgen products exclusively through Oncology Associates under the Oncology Associates/Amgen GPO Agreement by signing below. If you currently are purchasing Amgen products through another group purchasing organization, you must terminate your affiliation with that group purchasing organization for your Amgen product purchases and agree to purchase during the Oncology Associates/Amgen GPO Agreement term your future requirements for Amgen products through Oncology Associates pursuant to the terms and conditions of the Oncology Associates/Amgen GPO Agreement.

Declaration

On behalf of (Physician Practice Name) _____ and its legal affiliates purchasing Amgen products under other GPO, Oncology Associates, the undersigned hereby agrees to and certifies the following:

1. Physician Practice stated above hereby declares that it will not purchase Amgen products under any other affiliation agreement or arrangement;
2. Physician Practice Name stated above agrees to purchase all of its future requirements of Amgen products through Oncology Associates on the terms and conditions set forth in Group Purchasing Organization Agreement; and
3. The undersigned has the full power and authority to execute this Certification on behalf of Physician Practice stated above and its legal affiliates.

Signature: _____

Print Name: _____

Print Title: _____

Date: _____

DEA#: _____

PARTICIPATING MEMBER DECLARATION FORM "GLAXO"

*IF MORE THAN 1 LOCATION, PLEASE MAKE A COPY OF THIS DEC FORM AND LIST EACH LOCATION SEPARATELY.
* *Incomplete information will result in processing delays.*

Participating Member Name (Facility Name) _____

Physician Name _____

Address _____

DEA # (DEA address must match facility address) _____

City, State, Zip _____

Physician Name _____

Telephone # _____

DEA # (DEA address must match facility address) _____

E-mail address _____

HIN # _____

PLEASE LIST PRIMARY / SECONDARY DISTRIBUTOR AND/OR WHOLESALER

Distributor/ Wholesaler #1 _____

Distributor/Wholesaler #2 _____

The purpose of this form is to confirm the buying group affiliation of the above named entity. SmithKline Beecham Corporation d/b/a GlaxoSmithKline ("GSK") has a one buying group policy. GSK will recognize only one buying group as primary for the purchase of GSK products. By identifying the primary buying group below, the entity above is adopting all GSK product pricing for the primary group and foregoing all GSK product pricing through other buying groups.

The above named entity referred to as "Member" does hereby agree to purchase all GSK products exclusively under the _____ **buying group**. If "Member" is accepted and not currently participating in any other GSK contract, membership will be awarded within fifteen (15) days of receipt of this form. If Member was previously participating in another GSK contract it is understood that "Member" listed above shall be **removed** from any current group affiliation recognized by GSK other than that identified above and will forego pricing available therein. The effective date of the participation will be the first day of the next Rebate Period. If, for example, GSK receives and accepts the given Member's Dec Form on any date in the quarter January 1, 2007 to March 31, 2007, the effective date for such Member under this contract will be April 1, 2007.

PLEASE CHECK TYPE OF BUSINESS:

- Physician Clinic/Practice
- Occupational Health Clinic – Public Health Initiatives
- City/County/State Funded Health Clinic
- Outpatient Hospital Clinic
- Occupational Health Clinic – Private (Corporation)
- Oncology Clinic
- Acute Long Term Care
- Other (please describe: _____)

****AS INDICATED ABOVE - I, AS AN AUTHORIZED REPRESENTATIVE, WARRANT AND REPRESENT THAT THE FACILITY NAMED IN THIS REQUEST IS THE FOLLOWING BUSINESS TYPE _____ (**Required)**

CERTIFICATION: By signing below, Facility certifies, under penalty of perjury, that all of the above information is true and correct. Further, Facility certifies and agrees that (1) any GSK product purchased under any agreement shall be for its "Own Use," as defined by the United States Supreme Court in its opinions report at Abbott Laboratories et al. v. Portland Retail Druggist Association, Inc., 425 U.S. 1 (1976), and Jefferson County Pharmaceutical Association, Inc. v. Abbott Laboratories, et al., 103 S. Ct. 1011 (1983), and (2) GSK may, in its sole discretion, contact Facility's staff, and/or visit Facility's locations to verify that the above information is correct, and Facility agrees to provide such information to GSK as is reasonably necessary for GSK to make such a determination.

"Member" Authorized Signature _____

Primary Buying Group Authorized Signature _____

Print Name of Signature _____

Print Name of Signature _____

Title _____

Title _____

Date _____

Date _____

Please complete all sections and fax to: ATTN: Contract Operations, CRA (215) 933-3947

For Internal use only:

- CRA/Membership Coordinator verified member information; all updates will be fed from CARS to website.

Affiliation:

Accepted

Rejected if so, Reason _____

Initials _____

Additional Locations

Practice Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Telephone Number _____ DEA/HIN Number(s) _____

Fax Number _____

Practice Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Telephone Number _____ DEA/HIN Number(s) _____

Fax Number _____

Practice Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Telephone Number _____ DEA/HIN Number(s) _____

Fax Number _____

Practice Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Telephone Number _____ DEA/HIN Number(s) _____

Fax Number _____

Baxter BioScience

GPO DECLARATION FORM

Date: _____

Dear Membership Coordinator:

This is to notify you that effective _____, the facility listed below has selected **Oncology Associates** as its designated Group Purchasing Organization.

Please remove my facility from the following GPO (if applicable):

_____.

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

HIN# (Optional): _____ DEA#: _____

Baxter Account # (if known): _____

Member Signature / Title

Print Name

Date

CONTRACT PORTFOLIO QUALIFICATION QUESTIONNAIRE

To insure that you are awarded special contract pricing on those items currently utilized in your practice, please complete the following questionnaire:

MANUFACTURER NAME	COVERED PRODUCTS	CURRENTLY USING?	PARTICIPATE ON OA CONTRACT
APP	Abraxane®	Y N	Y N
AMGEN	Aranesp®	Y N	Y N
.....	Neulasta®	Y N	Y N
.....	Neupogen®	Y N	Y N
AVENTIS / RPR	Taxotere®	Y N	Y N
.....	Eloxatin®	Y N	Y N
BAXTER	Winrho®	Y N	Y N
GLAXO	Hycamtin®	Y N	Y N
EISAI	Aloxi®	Y N	Y N
ORTHO BIOTECH	Procrit®	Y N	Y N
NOVARTIS	Zometa®	Y N	Y N
PHARMION	Vidaza®	Y N	Y N
WYETH	Neumega®	Y N	Y N

Attention All New Members!

Important Membership Checklist

The following checklist has been created for you to highlight the necessary information we need to process your OA Membership. The earlier we can complete your OA Membership, the earlier you can begin to enjoy the vast amount of savings and value added services that are available through the Oncology Associates Group Purchasing Organization.

Please remember that we cannot process your membership unless *all* of the necessary paperwork is completed and returned to us. Please use the provided checklist to ensure you have completed all of the forms correctly and are returning them to us.

If you have any questions regarding the OA Membership, please contact your Account Manager at Florida Infusion and they will be able to help you. We are looking forward to working with you soon!

ONCOLOGY ASSOCIATES
Physician Network Services
a division of RC Medical, Inc.

MEMBERSHIP INFORMATION



Feel The Power Of Group Purchasing!

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For more information or questions, please call Oncology Associates at 888-732-7352 or your Account Manager at FloridaInfusion (800-624-0152) www.floridainfusion@att.net.