

**Integrated Vision Network (part of the Integrated Physician Networks)
 Membership Application Agreement**

For more information, please contact Member Services at (888) 536-7697 ext 6847.
 All completed forms should be returned via fax to Member Services at (866) 213-7780.

Membership Agreement

This Membership Agreement ("Agreement") is made by and between the Integrated Vision Network ("IVN") and ("Applicant")

effective as of (current date): _____

 Legal Name of Organization (Applicant)

 Address of Administrative Office

 City State Zip Code

Practice Information

By providing fax number and signing this agreement, Member hereby grants IVN permission to contact Member via fax in order to pass on information regarding educational meetings, product/pricing announcements, and/or any other information that IVN deems may be of interest to Member, consistent with the requirements set forth in the Junk Fax Prevention Act of 2005.

 Legal Name of Practice Tax ID

 Address of Practice

 City State Zip Code

Dispensing Location _____ Dispensing pharmacy on site: Yes No

 Number of Physicians in Practice Telephone Number Fax Number

 Office Contact

 Title E-mail Address

If there are additional qualifying sites, please attach a separate sheet identifying each with address, telephone and fax numbers.

| Physician(s) Name(s) | DEA Number | Medical Specialty | Professional E-mail Address |
|----------------------|------------|-------------------|-----------------------------|
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**If necessary, please list additional physician information in the designated section on the next page.*

