KNOW YOUR CUSTOMER QUESTIONNAIRE

Note: Questions refer to both controlled substances and List 1 chemicals – please check all applicable items in questions 1-3

1. Veterinary
   Practitioner: ☐ Teaching Institution: ☐ Humane Society: ☐ Researcher: ☐ Wholesaler: ☐
   Other (explain): _____

2. Dental
   Practitioner: ☐ Teaching Institution: ☐ Researcher: ☐ Wholesaler: ☐
   Other (explain): _____

3. Researcher**
   Teaching institution: ☐
   Other (explain): _____

   ***If you are a researcher, indicate type of research and research subjects. Attach a separate sheet if necessary.*

SECTION 1

DEA registrant name and DBA (if applicable): _____

DEA registration # / Expiration date: _____ Schedules: 2 ☐ 2N ☐ 3 ☐ 3N ☐ 4 ☐ 5 ☐ List 1 chemicals: _____

DEA registered address: Street: _____ City: _____ State: ____ ZIP: _____

Account name: _____

Account number: _____ Registrant phone number: _____

Registrant email address: _____

Registrant state licenses/registrations (please list number, type of license/registration, including separate controlled substance licenses and expiration dates):

State: _____ State Lic # _____ Type: _____ Expiration: _____

State: _____ State Lic # _____ Type: _____ Expiration: _____

State: _____ State Lic # _____ Type: _____ Expiration: _____

PATTERSON® COMPANIES, INC.

SECTION 2

Days and hours of operation:	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Ownership type: Sole proprietor: ☐ Partnership: ☐ Corporation: ☐ State of incorporation: ☐

Corporate officers: _____ _____

_____ _____

_____ _____

Other (explain): _____

Owner's name (if different than registrant in Section 1): _____

Owner's address: _____

Owner's phone number: _____

Has there been a change of ownership within the past 5 years? Yes ☐ No ☐

Is owner a licensed practitioner? Yes ☐ No ☐ Is owner practicing at the registered location? Yes ☐ No ☐

Primary practitioner: _____

Number of practitioners at the registered location: _____

Names and registrations/licenses of all practitioners, with or without DEA registration. For each practitioner, list name and, if these items apply, DEA registration number, controlled substances schedules listed on the Certificate of Registration and expiration dates. Attach copies of all registrations and licenses.

Name: _____ DEA #: _____ Schedules: _____ Expiration: _____

Name: _____ DEA #: _____ Schedules: _____ Expiration: _____

Name: _____ DEA #: _____ Schedules: _____ Expiration: _____

(Attach additional sheet if necessary)

SECTION 3

Is registrant or any practitioner/employee currently under investigation by any licensing authority, including DEA? Yes ☐ No ☐ (If yes, attach explanation.)

Has registrant or any practitioner/employee had a license or registration denied, revoked or suspended by any licensing authority, including DEA? Yes ☐ No ☐ (If yes, attach explanation.)

SECTION 4

Employee(s) responsible for controlled substance purchasing, reporting, recordkeeping, security:

Name: _____ Name: _____

Employee(s) authorized to sign DEA Forms 222 for Schedule II controlled substances on behalf of registrant:

Name: _____ Name: _____

Does employee authorized to sign DEA Forms 222 have a valid Power of Attorney on file at the registered location?
Yes ☐ No ☐ (If yes, please provide copies of power of attorney.)

For pharmacies only: Average number of all prescriptions dispensed to patients per day: _____

For pharmacies only: Average number of controlled substance/List 1 chemical prescriptions dispensed to patients per day: _____

For pharmacies only: List the top three most commonly prescribed controlled substances/List 1 chemicals dispensed to patients in an average week: _____

Average number of patients per day: _____

Average number of patients treated in a procedure or by administration of controlled substances/List 1 chemicals per day: _____

List the top three most common controlled substances/List 1 chemicals administered to patients in a procedure or otherwise: _____

_____

Average number of patients treated in a procedure or by administration with non-controlled medications each day: _____

SECTION 5

How often are controlled substances/List 1 chemicals ordered? Daily: _____ Weekly: _____ Monthly: _____ Other: _____

In an average month, when you order drugs for your practice, what percentage are (total should equal 100%):

Controlled substances: _____% List 1 Chemicals: _____% Non-controlled prescription only: _____%
Over The Counter / non-prescription: _____%

Do you purchase controlled substances from suppliers other than Patterson? Yes ☐ No ☐

Do you have a website? Yes ☐ No ☐ If yes, please provide URL: _____

If yes, does the website offer pharmaceuticals (prescription drugs and/or controlled substances) to the general public?
Yes ☐ No ☐

(If the website offers pharmaceuticals [prescription drugs and/or controlled substances] to the general public, you must attach a copy of your Verified Internet Pharmacy Practice Site (VIPPS) Accreditation or Verified Accredited Wholesale Distributor Accreditation.)

For dental offices only: Method of payment by patients/customers for controlled substance prescriptions (total should equal 100%):

Cash: _____% Insurance: _____% Medicaid/Medicare: _____% Check: _____% Credit Card: _____%
Electronic transfer: _____%

SECTION 6

Customer agrees and understands that Patterson Companies may provide a copy of this questionnaire to the DEA, other federal regulatory agencies and any state regulatory agency where appropriate.

I CERTIFY THAT THE INFORMATION PROVIDED IN THIS QUESTIONNAIRE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Print name and title of person who completed questionnaire:

Name (print) _____ Title _____ Date _____

Phone number _____

Signature _____ Date _____

FOR OFFICE USE ONLY

Date Rec'd _____ Date Reviewed _____ Reviewer _____

Follow-up Required Yes ____ No ____ Date Follow-up Completed _____

Notes: