

LETTER OF RESPONSIBILITY



AndaMEDS

Attn: Accounts Receivables Department
2915 Weston Road | Weston, FL 33331

To whom it may concern,

Please note that _____ (BUSINESS NAME)
will be financially responsible for payment on all purchases made by the authorized buyer(s) and/or physician(s) listed below.

TAX I.D NUMBER _____

Pharmacy Name _____

AUTHORIZED PURCHASER(S) PLEASE PRINT

Name _____ Title _____

Phone # (_____) _____ Fax # (_____) _____

Email _____

Name _____ Title _____

Phone # (_____) _____ Fax # (_____) _____

Email _____

SHIPPING ADDRESS

Address _____

Suite/Building _____

City _____ State _____ Zip Code _____

Phone # (_____) _____ Secondary # (_____) _____

Fax # (_____) _____ Email _____

Sincerely,

Name _____ Title _____

PLEASE PRINT

Authorized Signature _____ Date _____

**Once completed and signed, please fax form to your AndaMEDS
sales representative at 1-800-989-0700.**

Sales Representative Name _____

Any recipient of this fax may request that Anda, Inc. not send any future advertisements to this or other specified telephone facsimile machines. To make such a request, please call 1-888-511-4582 or 954-217-4691, fax the request to 954-217-4395 or e-mail your request to faxoptout@andanet.com • Your request must identify the telephone number of each facsimile machine to which the request relates • Once you opt out you will stop receiving any and all fax advertising materials to the facsimile number(s) you have registered • Your request will no longer be valid if, after your request is made, you provide express invitation or consent to Anda, Inc. to send advertisements to you at the identified facsimile numbers • Any failure to honor your request within 30 days is unlawful.