



Authorization for Purchase of Medical Devices

1 CUSTOMER, FACILITY, AND SHIPPING INFORMATION

Please Print or Type:

Company Name: _____ Account #: _____

Primary Contact/Title: _____ E-mail: _____

Authorized Purchaser(s): _____, _____, _____

Address: _____, City: _____, State: _____, Zip: _____

Company Shipping Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Alternate Telephone: _____

*If more than one shipping address is authorized, attach a signed list. Approval applies only to verified addresses.

2 PRODUCT CATEGORY AND CREDENTIAL INFORMATION

I, the undersigned, am a certified and/or licensed practitioner or authorized representative for the above-named facility and am legally authorized under the laws applicable to the purchaser and shipping destination to order the medical devices selected below. I authorize shipment only to the verified address(es) listed on this form and am submitting copies of all applicable professional licenses, facility or agency credentials, permits, certifications, or patient-specific prescriptions/orders.

___ Broad Medical Device Authorization (Examples: IV catheters and sets, needles and sharps, syringes, ET tubes, LMAs, rescue airways, and related supplies). **Approval is limited to products supported by applicable law and the submitted credentials; this selection does not guarantee approval of every medical device.**

___ Category-Specific Medical Device Authorization (Examples: suction units, pulse oximeters, bag valve masks, ventilators, hemostatic dressings, and related supplies). **Select each requested category in Section 3 of this form.**

Professional/Facility License or Credential #: _____ Type: _____ Issuing State: _____ Expiration: _____

3 PRODUCT CATEGORIES

- | | |
|---------------------------------|----------------------------------|
| 1. ___ IV Catheters | 9. ___ Video Laryngoscope |
| 2. ___ IV Admin Sets & Supplies | 10. ___ Suction Units & Supplies |
| 3. ___ Syringes | 11. ___ Hemostatic agents |
| 4. ___ Sharps & Needles | 12. ___ Oxygen Supplies |
| 5. ___ Ventilator & Supplies | 13. ___ Pulse Oximetry |
| 6. ___ CPAP & Supplies | 14. ___ Cardiac Supplies |
| 7. ___ Rescue Airways | 15. ___ Trauma Supplies |
| 8. ___ ET Tubes & Supplies | |

Certified and/or Licensed Practitioner/Authorized Representative Signature:

_____ Date: _____

4 STATEMENT OF AUTHORITY AND SIGNATURE**Select the authorization/documentation being provided:**

- ☐ Valid Prescription
- ☐ Physician/Practitioner Authorization
- ☐ Medical Director Authorization
- ☐ Facility/Agency Authorization
- ☐ Professional License/Credentials (only when applicable to the specific product requirement)

I certify that:

The authorization or credentials identified above are current and applicable to the medical device(s) being purchased; I am legally authorized to order the selected products or am an authorized representative of the facility/agency purchasing the products; all information and supporting documentation submitted is current, complete, and accurate; the products will be purchased for legitimate professional, facility, or agency use and used only by appropriately trained and supervised personnel; and the products will be stored, handled, and used in accordance with applicable laws, labeling, and professional requirements. I understand that WPSG may verify credentials, request additional documentation, restrict product categories, suspend authorization, or decline an order.

Certified and/or Licensed Practitioner/Authorized Representative Signature:

_____ Date: _____

Print Name: _____ **Title/Credentials:** _____

Instructions: This Authorization is valid only when accompanied by copies of all credentials, permits, certifications, or prescriptions/orders applicable to the products selected in Sections 2 and 3. Authorization expires on the earliest applicable credential expiration date or two years after submission, unless WPSG establishes an earlier date. A new Authorization and supporting documentation must be submitted upon expiration or whenever there is a change in licensed practitioner, medical oversight, facility status, authorized purchaser, approved shipping address, or applicable credential. The customer must promptly notify WPSG of any such change.

Please complete this form and submit copies of all applicable credentials, permits, certifications, or prescriptions/orders to Witmer Public Safety Group, Inc. by email to sales@wpsginc.com or by mail to 101 Independence Way, Coatesville, PA 19320, ATTENTION: Sales at the EMSstore. Submission does not guarantee approval.