



88 Hamilton Avenue, Stamford, CT 06902
203-658-9500
Fax: 203-658-9604
www.americares.org

MEDICAL OUTREACH PROGRAM

APPLICATION

Read carefully. Failure to correctly complete and return all required paperwork will delay your donation.

- We donate products to healthcare practitioners providing charitable medical services outside of the U.S. only.
- You must be personally traveling to the destination country and account for the use of the donated products.
- You must be licensed in the U.S. to prescribe medicine in order to request prescription medicines.
- **You must include a copy of your current state medical license with your request.**
- If you are not licensed to prescribe, you may request non-prescription products, if available.
- You must sign all forms. Forms signed by third parties will not be accepted.
- You can direct us to ship anywhere in the U.S. We do not ship overseas.
- Requests are limited to one donation per trip, regardless of number of participants, and two donations per year.
- Please allow approximately three weeks for processing your request.

REQUIRED PAPERWORK

- **Important Information** – Read carefully (do not return).
 - **Agreement for Acceptance and Distribution** – Read carefully, initial all items, sign & date.
 - **Agreement of Responsibility** – Complete, sign and date.
 - **Required Information Request** – Provide a summary of your upcoming trip (no brochures please).
 - **Inventory Approval Form** – For current list, contact Cia Marion (phone, fax, email shown below)
- Review carefully, complete and sign.
 - Our inventory is by nature short-dated and changes very rapidly. Please obtain an updated list if you do not submit your request promptly. We cannot donate products that will expire before or during your trip.
 - Please pay close attention to case limits, descriptions and expiration dates. We only donate by the case.
 - Please indicate all products that you can use. Asterisk (*) those that are most important. If we are out of a product, we can substitute with another choice. If we have excess product, we can give you more.
 - Our typical donation is 8-12 products (not cases), depending on availability.
 - If your required receipt date for products is more than six weeks away, you may opt to contact us no later than three weeks before that date to request an updated inventory. It is your responsibility to request another inventory.
 - You may request multiple inventories, but you can only submit one inventory request per trip.
 - All donations are final; no requested products can be returned to AmeriCares.

Please fax all completed paperwork to Cia Marion at 203-658-9604.

Any questions? I can be reached at 203-658-9528 or cmarion@americares.org.

We are happy to honor your request. However, the demand for products has increased to the point that we are now asking for a **suggested donation of \$200 per trip** to help offset the costs of providing this service. **This is not a fee**. All contributions are tax deductible. Details on making a donation are on the Required Information Request page.



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IMPORTANT INFORMATION – PLEASE READ CAREFULLY

TERMS OF AGREEMENT FOR ACCEPTANCE AND DISTRIBUTION

AmeriCares is a non-profit international disaster relief and humanitarian aid organization that provides support for all people around the world, irrespective of race, religion or political belief.

Although we realize that many groups making pro-bono medical trips are faith based, please note that products donated by AmeriCares are to be used for medical purposes only and not to advance any religious or political agenda. Access to health care for individuals seeking health services involving the use of these products will not in any way be affected by or conditioned upon the articulation of any religious or political belief, the submission to religious or political counseling or the attendance at any religious or political activity.

In reference to your recent request for a medical donation, please read the terms of the **Agreement for Acceptance and Distribution** carefully. By initialing and signing the Agreement for Acceptance and Distribution, you are affirming that our products will be used only in accordance with this agreement. Failure to uphold any of the terms of this Agreement will preclude future participation in this program.

CHOOSING PRODUCTS

When choosing products, please give careful consideration to extenuating factors such as whether there will be an on-going supply of products for chronic ailments, the availability of follow-up care and the degree of antibiotic resistance in the area to which you are traveling.

WE'RE VERY PROUD OF THE WAY WE MANAGE THE FUNDS CARING PEOPLE LIKE YOU GENEROUSLY DONATE.

A copy of the latest financial statement filed by AmeriCares may be obtained by contacting AmeriCares, 88 Hamilton Avenue, Stamford, CT 06902 (800-486-4357). Some states require that special notices be included with each solicitation. If you are a resident of one of these states, you may obtain financial information or annual report from us or directly from the state agency:

- In New York, Office of Attorney General, Charities Bureau, 120 Broadway, New York, New York 10271.
- In Maryland, for the cost of the copies and postage, the Secretary of State, State House, Annapolis, MD 21401.
- In New Jersey, from the attorney general by calling (973) 504-6215.
- In North Carolina, a copy of the license to solicit charitable contributions as a charitable organization or sponsor and financial information may be obtained from the charitable solicitation licensing section, North Carolina department of the secretary of state, by calling 1-888-830-4989.
- In Pennsylvania, residents may call the Pennsylvania Department of State at 1-800-732-0999 (in state only).
- In West Virginia, residents may contact the Secretary of State, State Capitol, Charleston, WV 25305.
- In Virginia, the State Division of Consumer Affairs, P.O. Box 1163, Richmond, VA 23209.
- In Washington State, residents may obtain a copy of the last report filed with the Washington Secretary of State by calling toll free within Washington, 1-800-332-4483 (in state only).
- In Florida, residents may call the division of consumer services at 1-800-435-7352 (in state only). Our Florida Registration number is SC-00910 and since AmeriCares does not employ professional solicitors, we retain 100% of contributions and 0% is retained by such solicitors.
- In Michigan, our license number is 10588.
- State of Kansas Registration #222F593F6SC; Office of Secretary of State, First Floor, Memorial Hall 120 S.W. 10th Avenue Topeka, KS 66612-1594. Copies of the filings with the authorities listed above can also be obtained by writing to AmeriCares at 88 Hamilton Ave., Stamford, Connecticut 06902. Registration with any of the above agencies does not imply endorsement by the state.



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AGREEMENT FOR ACCEPTANCE AND DISTRIBUTION

This form must be initialed and signed by the requesting health care practitioner who must be traveling to the destination country to oversee the use of the products there. To request prescription medicines, the requesting health care practitioner must have and provide a copy of a current U.S. license to prescribe medicine.

This agreement by and between AmeriCares and _____, the Consignee, signed this ____ day of _____, 2006 applies to shipments of donated materials by AmeriCares to the Consignee. This agreement will have an initial term of one year from the effective date, thereafter to be renewed, amended or extended as agreed by both parties.

- 1. AmeriCares is a nonprofit disaster relief and humanitarian aid organization that provides support for all people around the world, irrespective of race, religion or political beliefs. I agree to distribute products donated by AmeriCares in accordance with these requirements, and I agree that no one will be denied access to these products because of his/her race, religion or political beliefs. _____ (initial)
2. I agree that these products will be used for medical purposes only and not to advance any religious or political agenda. Access to health care for individuals seeking health services involving the use of these products will not in any way be affected by or conditioned upon the articulation of any religious or political belief, the submission to religious or political counseling or the attendance at any religious or political activity. _____ (initial)
3. In compliance with U.S. tax code 170(e)(3), I agree that all product donations will be distributed free of charge to each and every recipient and will be used exclusively for the care of the ill, needy or infants, and will not be re-exported or transferred in exchange for money, other property or services. _____ (initial)
4. AmeriCares is aware that some consignees charge nominal fees for patient visits, service access or like fees for service. I agree that any such fees do not include charges for donated materials supplied by AmeriCares and that no one will be denied access to AmeriCares' donated medicines and supplies because of his / her inability to pay. _____ (initial)
5. I agree to follow all labeling guidelines and manufacturers' recommendations for proper use of all products and to make every attempt to distribute donated medicines before their expiration date. Expired medicines will not be distributed. In the case where product must be destroyed (such as lapse of expiry dating), I will notify AmeriCares and will handle that product in compliance with the manufacturer's recommendations and the recipient country's regulations. _____ (initial)
6. I agree to be responsible for the proper transportation of all materials received from AmeriCares for this trip. AmeriCares will transport the materials within the United States. I will be responsible for ensuring proper transportation and customs clearance of donations to international project sites. I understand that all products must leave the United States, must be used in the destination country under my personal supervision and that no products can be returned to AmeriCares. _____ (initial)
7. AmeriCares requires follow-up reports related to the receipt and use of donated supplies, both for internal use and at the request of our corporate donors. A Confirmation of Shipment Form will be sent to me when the shipping order is submitted. I agree to promptly sign and return this form upon receipt of the shipment. _____ (initial)
8. Within one month of my return from this trip, I agree to provide AmeriCares with a brief description of my trip, summarizing the number of patients served, the administration of the donated medicines, any adverse reactions to the donated medicines and the disposition of any unused or damaged donated medicines. _____ (initial)
9. I understand that AmeriCares reserves the right to conduct a personal inspection of my and/or my sponsoring organization's distribution systems and records to ensure full compliance with this Agreement and that failure to uphold any of the terms of this agreement will preclude future participation in this program. _____ (initial)

Cia Marion

Cia Marion, Manager
AmeriCares Medical Outreach Program

Consignee (Signature)
Consignee (Print name)



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AGREEMENT OF RESPONSIBILITY

By completing and signing this form, you affirm that you will personally oversee the use of and will take full responsibility for medicines and medical supplies donated by AmeriCares. Only individuals licensed to prescribe medicine may order prescription medicines. In compliance with the Prescription Drug Marketing Act and Internal Revenue Service regulations, these medicines and supplies will not be used, marketed in, or returned to the United States, nor be sold or exchanged for property or services. All medicines and medical supplies will be used only in treating the ill, needy or infants, will be distributed free of charge and will be distributed irrespective of race, and not to advance any religious or political agenda. **Any lost, misplaced, or stolen supplies must be reported to AmeriCares immediately.**

I am licensed in the U.S. to prescribe general medicines: Yes _____ No _____
I have the following license: _____ (MD, DO, DDS, CRNA etc.) Specialty (if any): _____
I am sending a copy of my current U.S. state medical license with this paperwork: Yes _____ N/A _____

_____ Name of Requesting Healthcare Practitioner	_____ Trip Dates (Departure and Return – please use actual dates)
_____ Address of Requesting Healthcare Practitioner	_____ Destination Country (include city, town, etc. if applicable)
_____ Address (line #2)	_____ Name and Location of Destination Country Medical Facility (if any)
_____ City, State, Zip	_____ Name of Destination Country Follow-Up Care Provider (if any)
_____ Best Telephone Number(s) to Reach You (office, cell, pager, home) Please specify.	_____ Address of Destination Country Follow-Up Care Provider (if available)
_____ Fax Number of Requesting Healthcare Practitioner	_____ Address of Destination Country Follow-Up Care Provider (line #2)
_____ E-mail Address of Requesting Healthcare Practitioner	_____ Tel Number and/or e-mail address of Follow-Up Care Provider (if any)

 Signature of Requesting Healthcare Practitioner

 Date

Shipping information, if different from above (we only ship to addresses in the U.S.)

 Name

 Address (line #1)

 Address (line #2)

 City, State, Zip

 Telephone Number

 Fax Number/Email Address



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REQUIRED INFORMATION REQUEST

Please provide the following information for consideration of your request (no brochures please):

Name of Requesting Healthcare Provider: _____

Name and address of Sponsoring Organization (if any): _____

Note: If sponsoring organization is a U.S. Private Voluntary Organization, please send a copy of the IRS determination letter indicating its 501(c)(3) status.

Name and address of Recipient Institution in Destination Country (if any): _____

How did you learn about the AmeriCares Medical Outreach Program?

Pharmaceutical Company (name) _____ Sales Rep. (name) _____

I have received a prior donation. Word of mouth Other _____

Date of departure: _____ Want meds by: _____ Need meds by: _____

Please use actual dates. Do not use ASAP. These dates determine what, when and whether we can ship.

Destination country: _____ # of patients to be treated: _____

Types of cases to be seen: _____

Any additional information about your trip: _____

In order to help defray AmeriCares Medical Outreach Program shipping and administrative costs, I am making a donation in the amount of \$_____ (suggested: \$200). I authorize you to charge my credit card as follows:

Name of Cardholder: _____ Type of Card: _____

Card number: _____ Expiration date: _____

Billing address _____ City, State, Zip: _____

Billing Tel.#: _____ Signature: _____

Checks may also be mailed to AmeriCares, Medical Outreach Program, 88 Hamilton Avenue, Stamford, CT 06902. Credit card donations can also be made over the phone by calling Cia Marion at 203-658-9528 and leaving the information requested above on our secure voicemail. If you prefer to use our website at www.americares.org, choose the AmeriCares Humanitarian Fund option, but please notify Cia of your donation so that it can be properly attributed to your medical donation request. Your donation is tax-deductible and a receipt will be sent for tax purposes within 4 weeks. Thank you in advance for helping to offset the costs of providing this service. Please read the accompanying disclaimer.