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M A G N E T

Mid-Atlantic  
Group Network of  
Shared Services

Dear Prospective Vendor:

Thank you for inquiring about becoming an approved MAGNET vendor. This letter and accompanying information will give you a brief introduction of our company, our history, and our structure.

Founded in 1979, MAGNET is one of the oldest, most experienced and largest shared service organizations in the country. MAGNET's membership is comprised of seven group purchasing/shared service organizations that, in turn, market directly to over 700 hospitals, 1,000 long term care facilities, and 5,000 physicians/clinics in the northeastern United States. Attached is a company profile, which you should complete and return to us with literature detailing the products/services you offer. After we have received it, we will review the information and contact you if the opportunity exists for a further relationship. (Regrettably, time does not permit us to follow-up with every vendor who supplies information to MAGNET. If we currently have another agreement for the products/services offered by your company; we will maintain your information on file and contact you in the future when the agreement is renegotiated.)

If you should have any questions regarding the enclosed information, please feel free to contact us. Thank you, in advance, for your interest in MAGNET.

Sincerely,

*Steve*

Steven R. Duke  
Vice President



## COMPANY PROFILE

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1. **Company Name:** \_\_\_\_\_
2. **Address:** \_\_\_\_\_  
\_\_\_\_\_
3. **Ownership:**  Private  Public Stock Exchange: \_\_\_\_\_ Symbol: \_\_\_\_\_
4. **Year Incorporated:** \_\_\_\_\_
5. **Phone:** \_\_\_\_\_
6. **Toll Free:** \_\_\_\_\_
7. **Fax:** \_\_\_\_\_
8. **E-Mail:** \_\_\_\_\_
9. **WEBSITE Address:** \_\_\_\_\_

## HISTORICALLY UNDERUTILIZED BUSINESSES

10. **If your company qualifies as a historically underutilized business, please check the appropriate category:**

- Certified Minority Owned Business
- African American Owned Business
- Asian Owned Business
- Hispanic Owned Business
- Native American Owned Business
- Certified Woman Owned Business
- Certified Disabled Owned Business
- Certified Veteran Owned Business
- Certified Services Disabled Owned Business
- Small HUB Zone Business



**PERSONNEL**

11. Number of Employees: \_\_\_\_\_

12. Top THREE Company Employees:

NAME

TITLE

Years with Company

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. Contact person for Sales:

\_\_\_\_\_ This individual is a(n)  Employee  Consultant

14. Contact person for National Accounts:

\_\_\_\_\_ This individual is a(n)  Employee  Consultant

15. If we had an agreement with your company, our contact person would be:

**NAME:** \_\_\_\_\_ **EMAIL :** \_\_\_\_\_

**PHONE:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**SALES / MARKETING**

16. How do you sell/market your products? (List all that apply)

“Direct” Sales Reps. \_\_\_\_\_ %    Telemarketing \_\_\_\_\_ %    Direct Mail \_\_\_\_\_ %  
“Independent” Sales Reps. \_\_\_\_\_ %    Distributor \_\_\_\_\_ %    Through Distribution \_\_\_\_\_ %

17. What percentage of your company's business is:

**Direct?** \_\_\_\_\_ %    **Through Distribution?** \_\_\_\_\_ %

18. If applicable, name the major distributors you work with:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**19. If applicable, list your company's TOP THREE (3) Manufactured Products:**

<u>PRODUCT NAME</u>	<u>GENERIC DESCRIPTION</u>	<u>Total Product Rating*</u>	<u>% of Your \$ Market</u>	<u>Sales</u>

*\*Rate your products 1-5 where 1=being generic/price sensitive and 5=being specialty/sales sensitive*

**20. Who/what do you consider your major competition? PLEASE LIST:**

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**21. To which user group(s) do you sell your products? (List all that apply)**

Hospital \_\_\_\_\_ %      Home Healthcare \_\_\_\_\_ %      Long Term Care \_\_\_\_\_ %  
 Physician \_\_\_\_\_ %      Other \_\_\_\_\_ %      **Describe:** \_\_\_\_\_

**22. To help us in determining where best to market your products, if we have an agreement, please indicate below any and all areas where your products are utilized:**

**ACUTE CARE (Hospital)**

- Administration
- Anesthesia
- Emergency Room / Trauma Center
- Food Service
- General Nursing Units
- Housekeeping / Environmental Services
- ICU / CCU
- Laboratory
- Maternity / Women's Health / Nursery / NICU
- Operating Room / Outpatient Surgery
- Pediatrics
- Physical Medicine / Rehabilitation Therapy
- Pulmonary Medicine / Inhalation Therapy
- Radiology

**Other Departments:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**NON-ACUTE**

- Ambulatory Care Centers
- Assisted Living Centers
- Blood Bank, "Free Standing"
- Clinics, "Free Standing"
- Dialysis Centers
- Home Health Agency / VNA
- Imaging Center
- Independent Pharmacy
- Long Term Care Facility
- Nursing Home
- Outpatient Rehabilitation
- Outpatient Surgery Centers
- Physician Offices
- Sub-Acute Care Facility

**Other Healthcare Settings:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



MISCELLANEOUS

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23. If applicable, your company's current FDA registration is as a:

- Medical Device Manufacturer Drug Manufacturer Biologics Manufacturer

24. Are your products ISO approved?

- YES NO Not Required

25. Help us understand the process used with "Sales Leads" that are generated:

What specific information do you want provided with any "Sales Leads"?

Three horizontal lines for text input.

Who should get the "Sales Lead" information?

Two horizontal lines for text input.

How much time will typically elapse between when the "Sales Lead" is provided and when the customer is contacted?

Two horizontal lines for text input.

Will the local sales rep know that the "Sales Lead" came as a result of the MAGNET contract?

- YES NO

Will you provide us "feedback" on the status of the "Sales Lead"?

- YES NO

If so, how soon should we expect a report?

Two horizontal lines for text input.

How frequently thereafter?

Two horizontal lines for text input.

Name, Title & Phone Number of person that completed this form:

Name: Title: Phone: (with horizontal lines for input)

