



Dear Prospective Vendor:

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

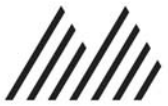
Founded in 1979, MAGNET GROUP is one of the oldest, most experienced and largest shared service organizations in the country. MAGNET GROUP's membership is comprised of corporate owned and regional purchasing/shared service organizations that, in turn, market directly to over 700 hospitals, 1,000 long 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 GROUP. 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 GROUP.

Sincerely,

Steven R. Duke
Executive Vice President & COO
MAGNET GROUP
4823 East Trindle Road, Suite 300
Mechanicsburg, PA 17050
Phone: (717) 763-5555
FAX: (717) 763-7464
www.magnetgroup.com



COMPANY PROFILE

1. **Company Name:** _____
2. **Address:** _____

3. **Ownership:** Private _____ Public _____ Stock Symbol _____
4. **Year Incorporated:** _____
5. **Phone:** _____
6. **Toll Free:** _____
7. **Fax:** _____
8. **WEB Site Address:** _____

HISTORICALLY UNDERUTILIZED BUSINESSES

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

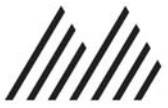
- Certified Minority Owned Business
- Certified Woman Owned Business
- Certified Disabled Owned Business
- Certified Veteran Owned Business
- Certified Services Disabled Owned Business
- Certified Small HUB Zone Business

PERSONNEL

10. Top THREE Company Employees:

NAME	TITLE	Years with Company
_____	_____	_____
_____	_____	_____
_____	_____	_____





11. Contact person for Sales:

_____ This individual is a(n) Employee Consultant

12. Contact person for National Accounts:

_____ This individual is a(n) Employee Consultant

13. Contact person for Marketing:

_____ This individual is a(n) Employee Consultant

14. If we enter into an agreement with your company, our contact person that is not an outside consultant would be:

NAME: _____ EMAIL : _____

PHONE: _____ FAX: _____

SALES / MARKETING

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

"Direct" Sales Reps. _____ % Telemarketing _____ % Direct Mail _____ %

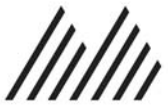
"Independent" Sales Reps. _____ % Distributor _____ %

16. What percentage of your company's sales are:

Direct? _____ % Through Distribution? _____ %

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





18. On a separate sheet – Describe your current healthcare marketing plan. Include how you promote and sell your products and how your products drive down costs within the context of protecting high quality care.

19. Please attach a copy of your reps and give a brief description of how you communicate with them.

20. Do you have inside sales representatives? _____ If so, how many? _____

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

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

Hospital _____ % Home Healthcare _____ % Long Term Care _____ %

Physician _____ % Other _____ % Describe: _____

23. To help us determine where best to market your products, if we enter into an agreement, please indicate below any and all areas where your products are utilized:

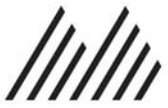
ACUTE CARE (Hospital)

- 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

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

- Medical Device Manufacturer
- Drug Manufacturer
- Biologics Manufacturer

25. Are your products ISO approved?

- YES NO Not Required

26. If awarded a contract you will be required to capture and report sales to **MAGNET GROUP** with **MAGNET GROUP Facility #, Facility Name, Address, Sales per Facility and Administrative Fee per Total Sales. and Amount of Sale & Admin Fee. Please attach a sample copy from your system of such a report we can expect.**

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

Name: _____

Title: _____

Phone: _____ Email: _____