VRS
HDA VERIFICATION ROUTER SERVICE PROVIDER NETWORK

Healthcare Distribution Alliance: Verification Router Service Provider Network (VRS PN) Membership Application Form

The Verification Router Service Provider Network (VRS PN) is a Healthcare Distribution Alliance (HDA) service offering that provides a forum for the pharmaceutical supply chain industry's thought leaders on technology-based solutions and innovation to network with peers and regulatory officials, participate in meetings and exchange information that advances ongoing interoperability for DSCSA compliance.

VRS PN is a separate and distinct offering within the HDA. VRS PN member companies that are not also members of HDA in other membership categories are not afforded access to the full range of HDA member benefits. Examples of exclusions include attendance to HDA's Business and Leadership Conference, access to non-VRS PN committees and other HDA-specific programs and services.

INSTRUCTIONS

1. Complete each question on the application form. Please type or print clearly and make a copy for your records.
2. VRS PN reserves the right to request additional information as needed.
3. **You will be billed for your membership dues once your application has been approved. Dues are payable by January 31 each year.**
4. The completed application should be returned to HDA at:

Email: Dues@hda.org
Fax: (202) 831-0969
Mail: HDA
Attn: Accounts Receivable
1275 Pennsylvania Avenue NW, Suite 600
Washington, DC 20004
ACH: Contact Dues@hda.org or (202) 964-6667 for transfer details.

Application processing takes an average of 15 business days from the date received.

For further information or assistance regarding membership, contact
Jaidalyn Rand, Director, Industry Relations, at (202) 935-6406 or jrand@hda.org or
Lisa Kanfer, VP, Membership and Development, at (202) 964-6066 or lkanfer@hda.org.

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Membership Categories

FULL MEMBERS:

$10,000 for existing HDA Service Provider Members; $12,500 for non-HDA Service Provider Members.

Full Members include business entities that have an interoperable VRS solution or related interoperable solution. Full membership is reserved for active VRS Provider Network Participants who have completed interoperability testing and have committed to ongoing interoperability. These members have a VRS product.

AFFILIATE MEMBERS:

$3,000 for existing HDA Service Provider Members; $5,000 for non-HDA Service Provider Members.

Affiliate Members are business entities that have an interoperable VRS solution or related interoperable solution or a business entity that is aspiring to developing a VRS solution, product or related interoperable solution for DSCSA compliance.

I AM APPLYING FOR THE FOLLOWING MEMBERSHIP CATEGORY:

❑ **FULL MEMBER**

❑ **AFFILIATE MEMBER**

APPLICANT NAME

Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Phone: _____ Website: _____

Profile* (35–200 words): _____

_____

_____

_____

_____

**HDA reserves the right to edit as necessary.*

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KEY CONTACT:

(The key contact will be the recipient of all VRS PN membership information, including dues invoices.)

Name: _____ Title: _____

Key Contact's Preferred Mailing Address *(to be listed in member directory):*

_____

City: _____ State: _____ Zip: _____

Email *(company domain email address)*: _____

Phone *(to be listed in member directory)*: _____

CERTIFICATION/MISSION

The company certifies that its responses contained herein are accurate, and by submitting this application, agrees to provide to HDA any additional information necessary to assure the accuracy of its responses.

VRS Provider Network Mission Statement:

The mission of the VRS Provider Network is to provide the structure for the maintenance of interoperability across the VRS Provider Network participants in coordination with the industry stakeholders to support FDA and other industry requirements pertaining to the DSCSA.

I have read the above mission statement and wish to promote those objectives.

Name of applicant: _____

Signature: _____ Date: _____

PAYMENT INFORMATION:

Amount: _____

❑ Full Member ❑ Affiliate Member

Please charge my: ❑ Mastercard ❑ Visa ❑ American Express ❑ Check # _____

Cardholder's Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ Exp. Date: _____ CVV: _____

Signature: _____

Checks may be made payable to HDA. Mail checks to:

HDA
Attn: VRS PN Membership
1275 Pennsylvania Avenue NW, Suite 600
Washington, DC 20004

Payments to HDA or its VRS PN division are not tax deductible as charitable contributions for federal income tax purposes. However, they may be deductible under other provisions of the Internal Revenue Code. Tax ID #13-1088150.