

LETTER OF RESPONSIBILITY



Akron Generics

Attn: Accounts Receivables Department

47 Mall Drive, Unit 1 & 2,
Commack, NY, 11725.

To whom it may concern,

Please note that _____ (BUSINESS NAME)

will be financially responsible for payment on all purchases made by the authorized buyer(s) and/or physician(s) listed below.

TAX I.D NUMBER _____

Pharmacy Name _____

AUTHORIZED PURCHASER(S) PLEASE PRINT

Name _____ Title _____

Phone # (_____) _____ Fax # (_____) _____

Email _____

Name _____ Title _____

Phone # (_____) _____ Fax # (_____) _____

Email _____

SHIPPING ADDRESS

Address _____

Suite/Building _____

City _____ State _____ Zip Code _____

Phone # (_____) _____ Secondary # (_____) _____

Fax # (_____) _____ Email _____

Sincerely,

Name _____ Title _____

PLEASE PRINT

Authorized Signature _____ Date _____

Once completed and signed, please fax form to your Akron Generics sales representative at (631)-215-3099

Sales Representative Name _____

Any recipient of this fax may request that Akron Generics, LLC. not send any future advertisements to this or other specified telephone facsimile machines. To make such a request, please call (631) 215-3009, fax the request to (631)-215-3099 or e-mail your request to info@akrongenerics.com • Your request must identify the telephone number of each facsimile machine to which the request relates • Once you opt out you will stop receiving any and all fax advertising materials to the facsimile number(s) you have registered • Your request will no longer be valid if, after your request is made, you provide express invitation or consent to Akron Generics, LLC. to send advertisements to you at the identified facsimile numbers. • Any failure to honor your request within 30 days is unlawful.