

Addendum to the Merck Vaccine Patient Assistance Program Application
Section 2: Licensed Prescriber Information

This addendum to the application for the Merck Vaccine Patient Assistance Program is to be completed by the Medical Director responsible for the Standing Order for the below healthcare facility

Physician Name	
Physician tax State License Number (must be active and valid)	
Practice Facility Address (please provide a street address only, no PO boxes)	
City/State/Zip	
Phone: Fax:	
Office contact person	
Office contact number	

By signing below, I represent and warrant the following:

- I have an executed Standing Order that covers the vaccinations in the Practice/Facility as provided herein, which I agree to provide to the Merck Vaccine Patient Assistance Program upon request.
- My Standing Order has been prepared exclusively for adult vaccinations within this Practice/Facility.
- I understand that a copy of this addendum will be provided to the Merck Vaccine Patient Assistance Program along with a completed application for the Merck Vaccine Patient Assistance Program for each individual patient requesting enrollment.
- I understand that this Practice/Facility has obtained written authorization from the patient identified in this request to disclose the patient's personal health information (PHI), including information relating to the patient's medical condition and prescription medications and the information disclosed in this application to the Merck Vaccine Patient Assistance Program, sponsored by the Merck Patient Assistance Program, Inc., the administrator of the Program, including its subcontractors or other affiliates, for the Merck Vaccine Patient Assistance Program to use and disclose the information for the purposes of providing services through this Program.
- I certify that I, or a physician in my Practice, has determined that the prescribed product is medically appropriate for the patient identified on the accompanying completed Merck Vaccine Patient Assistance Program application and that I, or a physician in my Practice, will be supervising the patient's treatment.
- I understand that if the patient receives product through the Merck Vaccine Patient Assistance Program, neither the patient nor this Facility/Practice may seek reimbursement or credit for this vaccine from any insurer, health maintenance organization, or government program.
- I understand that neither I nor this Practice/Facility will receive any reimbursement from Merck, whether for administration fees or otherwise.
- I understand that information concerning program participants may be summarized for statistical or other purposes and provided to Merck and/or the Program, but that any such summary shall be of de-identified data and shall not disclose, nor be able to be used to disclose, the patient's identity.
- I verify that the information provided is complete and accurate to the best of my knowledge.

MEDICAL DIRECTOR - SIGNATURE AND DECLARATION

Physician's original signature: _____ Date: _____

Physician's name (please print): _____