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 <u>that is not an outside consultant</u> would be:

NAME: _____ PHONE: _____

EMAIL: _____ 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. 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: _____