MAGNET GROUP GPO
MID-ATLANTIC GROUP NETWORK OF SHARED SERVICES, INC.

Return to: magnet@magnetgroup.com

COMPANY PROFILE

1. **Company:** _____

2. **Address:** _____

3. **City/St/Zip:** _____

    State: _____   **Zip Code:** _____

4. **Ownership:**   **Private**   **Public**   **Stock Symbol** _____

5. **Year Incorporated:** _____

6. **Phone Number** _____   **Toll-free:** _____

7. **Fax Number** _____

8. **Website:** _____

9. **If your company is CERTIFIED as a historically underutilized or minority business, please check the appropriate category or categories (check all that apply**):

    Disabled Owned Business   **Minority Owned Business**

    Services Disabled Owned Business   **Small HUB Zone Business**

    Veteran Owned Business   **Woman Owned Business**

10. **Top Three Company Employees:**

Name	Title	Years with Company
_____	_____	_____
_____	_____	_____
_____	_____	_____

11. **If we enter into an agreement with your company, our contact person <u>who is not an outside consultant</u> would be:**

_____	_____
Name	**Title**
_____	_____
Email	**Phone**

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

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

        Independent Sales Reps _____%   **Distributors _____%**

13. What percentage of your sales are Direct _____%   through Distribution _____%

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

    _____

    _____

15. 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.

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

17. Do you have inside sales reps? _____   If yes, how many? _____

18. Who / what do you consider your major competition? Please List.

    _____

    _____

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

        Hospital _____%   **Surgery Center _____%**   **Imaging Center _____%**

    Long Term Care _____%   Other _____% Describe _____

20. If awarded a contract, you will be required to capture and report sales to MAGNET GROUP GPO with MAGNET GROUP GPO Facility #, Facility Name, Address, Sales per Facility and Administrative Fee per Total Sales. Please attach a sample report from your system.

21. Name, title, email and phone number of person that completed this form:

    _____   _____

        Name   **Title**

    _____   _____

        Email   **Phone**