SM/sos **DISTRIBUTOR / DEALER INFORMATION DETAIL (DID) – PROPOSED / EXISTING** **(Please Tick ✓)**

IDENTIFICATION

1. Firm / Company **Name** : Messers _____

2. Whether **status** is PROPRIETORSHIP ☐ / PARTNERSHIP ☐ / COMPANY ☐ (If yes, please tick✓)

3.**a**. Name of the full time **PROPRIETOR / PARTNERS / DIRECTORS :**
1. _____ (Mobile / Tel. no._____), Meeting day / time _____ / _____.
2. _____ (Mobile / Tel. no._____), Meeting day / time _____ / _____.

3.**b**. AUTHORIZED full time **MANAGER** / Contact Persons :
1. _____ (Mobile / Tel. no._____), Meeting day / time _____ / _____.
2. _____ (Mobile / Tel. no._____), Meeting day / time _____ / _____.

4. Postal **Address (**Preferably **H.O.) :** _____

_____

City : _____ **Pin Code** : ☐☐☐☐☐☐ **State** : _____ **Land Mark** : _____

Floor : _____, **Area** (main working) : _____ (Approx), **Storage Space** (other than main working area) : _____, **Front / Back Side** (pl. tick ✓).

5. **Telephone** No. (with STD code) Office : _____ Residence : _____ Mobile No.: _____

6. **Fax** No. (with STD code) : _____ 7. **Email** : _____

STRENGTH

8. **Presently** Products / **Brand** dealt with (specify name) : _____ similar to **'medi' / 'Sissel'** – Y/N (pl. tick ✓).
If **'Y'** which **'brand'** _____

9. **Presently** Distributor / C&F / Dealer for (Specify Name): _____ dealing with any **'medi'/'Sissel' dealer anywhere in INDIA**–Y/N (pl.tick✓).If **'Y' name** of the party _____

10. Present **Area** / **City** of work AND if now also interested (specify name) :_____

11. Total no. of **Hospital** and presently interested with – **Private** - **OPD** covered - Yes / No. If yes, how many and specify few **names** (Hospital) with distance (approx.) : _____

Directly supplied to-Yes/No. If yes, how many and specify few **names** (Hospital) with **distance** (approx.): (Please attach the copy of Supply Proof) _____

_____

Govt. - Directly supplied to-Yes/No. If yes, how many and specify few **names** (Hospital) with **distance** (approx.): (Please attach the copy of Supply Proof)

_____

12. **Total no.** of **speciality** (doctors) **&** presently **covered** with:

Cardiology / medicine	Vascular / CVTS	General Surgery	Ortho	Neuro	Physio	Gynae	Onco	Plastic	ICCU / ITU
&	&	&	&	&	&	&	&	&	&

13. Present full time **Manpower** : Administration (Nos) :_____**Marketing People** → Delivery Man (Nos) :_____Meeting with doctors (Nos) : _____

14. **Investment** Interest at first point for new products : **Rs.** _____ (Not required for existing distributors)

SCOPE

15. Now interested for:**medi** GmbH & Co.KG, GERMANY→Yes/No, **Sissel**, GERMANY→Yes/No, **Hallufix**, GERMANY→Yes/No, **Hold Cold Compression,**→Yes/No, **Dispotech** Products→Yes/No, **HOLD** Physio & Rehab→Yes/No

16. If '**Yes**', above, specify amount of purchase **per month** to be made for following product range (on the basis of city Eco sheet attached) :

- Stockings for LEG- Anti Embolism Stocking **(AES)** - Yes / No (mediven® thrombexin® 18 / mediven® struva® 23 & 35) If yes, **Value in Rs.** _____
  Medical Compression Stockings **(MCS)**-Yes/ No (duomed® / mediven® plus / mediven® forte) If yes, **Value in Rs.** _____
- Armsleeves for ARM **(MCA)** - Yes / No , If yes, **Value in Rs.** _____.
- lipomed® basic for BODY **(MCG)** - Yes / No If yes, **Value in Rs.** _____.
- lipomed® face for FACE ⇨ Yes / No If yes, **Value in Rs**. _____.
- lipomed® bra for BREAST ⇨ Yes / No If yes, **Value in Rs.** _____.
- Orthopaedic Supports-Low Value **(OTC)** - Yes / No (Elastic supports – 501, 601, 603, 605, Genumedi, Epicomed, Lumbar Supports, Achimed, Levamed, medi Step, Thumb Support, Wrist Support, Philadelphia Collar) If yes, **Value in Rs.** _____
  High Value (Functional **Brace**) - Yes / No (3C, 4C, 4C Flex, Spinomed, Hinged Knee, medi ROM, M.3OA, M.4OA, medi ROM, Walker) If yes, **Value in Rs.** _____
- Hallufix Products - Yes / No If yes, **Value in Rs**. _____
- Hold Cold Compression - Yes / No If yes, **Value in Rs**. _____
- Dispotech Products - Yes / No If yes, **Value in Rs**. _____
- Sissel Products - Yes / No If yes, **Value in Rs**. _____
- Hold Physio & Rehab Products – Yes / No If yes, **Value in Rs**._____

Total Value in Rs. _____ ***(Rupees*** _____)

AUTHENTICATION

:17.GST No.:_____,**18. PAN**:_____,**19. Drug** License No.1/2 : _____
(Please attach the Xerox copy) (Please attach the Xerox copy) (Please attach the Xerox copy)

20. **Recommended** for (on the basis of city Eco sheet attached) : I. **HP–IP** – Y/N (pl. tick ✓) II. **OPD** (speciality) _____ III. **OTC (SO)** _____ **OTC – PO (S+OP)** ___ **OTC – PT (SO)** ___ – N / S / E / W / C – Y/N (pl. tick✓). If **'Y'** nearby to **Hospitals and ED's** (please specify names) **:**

_____

21. **ATTACHMENTS** (xerox copies wherever applicable) : **Visiting Card** ☐, Explanation **(Discussion)** Sheet ☐, **Purchase Order** ☐, **PRF (Measurement)** Sheet ☐, **Latest Supply Proof** – Invoice / Order of each hospital (if HP-IP) ☐, **GST No.** ☐, **PAN** ☐, **Drug Licence** 1 / 2 if any ☐, **Do's & Don'ts Guidelines** ☐, **Complain guidelines** along with **product complaint form** ☐. **Monthly Purchase Target Sheet** ☐,

22. Special Comments: _____

Date | Signature of PMIPL | Signed by Distributor / Dealer with Seal

DECLARATION FROM DISTRIBUTOR / DEALER – PROPOSED / EXISTING (Please Tick✓)

Name of Proposed Distributor/Dealer _____ City: _____

Name of Authorised Person _____ Designation: _____

The present business activities relating to our product ranges are: **(please tick √ whichever is applicable)**

☐ If **HP-IP** willing to supply directly to any **Hospital** or **Hospital's In house-Pharmacies** , then please fill-up the following and attach the latest supply proofs (compulsory)**:** (As per Serial No. **11**) (Additional sheet can be used for more no. of **HP's**)

Sl.	Name Of Hospitals	CC Beds	Sl.	Name of Hospitals	CC Beds
1.	_____	_____Nos.	4.	_____	_____Nos.
2	_____	_____Nos.	5.	_____	_____Nos.
3	_____	_____Nos.	6 .	_____	_____Nos.

☐ If **OPD** willing to cover **Doctors** from different specialities in the Out Patient Department of different Hospitals or Pvt. Chambers, then please fill-up the following**:** (As per Serial No. **12**) (Additional sheet can be used for more no. of **Drs**)

Sl.	Name Of Doctors	Spl.	Hosp./ Pvt . Clinic / Chamber	Sl.	Name of Doctors	Spl.	Hosp./ Pvt . Clinic / Chamber
1.	_____	_____	_____	8.	_____	_____	_____
2.	_____	_____	_____	9.	_____	_____	_____
3.	_____	_____	_____	10	_____	_____	_____
4.	_____	_____	_____	11.	_____	_____	_____
5.	_____	_____	_____	12.	_____	_____	_____
6.	_____	_____	_____	13.	_____	_____	_____
7.	_____	_____	_____	14.	_____	_____	_____

☐ If **OTC** willing to sell our products to the patient or end users from your own counter or clinic or centre , then please fill-up the following **:** (fill the name of supporting **Doctors** or mention 'Own Effort' if sold to own patients or end use) (As per Serial No. **12**) (Additional sheet can be used for more no. of **Drs**)

Sl.	Name Of Supoorting Doctors	Spl.	Hosp./ Pvt . Clinic / Chamber	Sl.	Name of Supporting Doctors	Spl.	Hosp./ Pvt . Clinic / Chamber
1.	_____	_____	_____	5.	_____	_____	_____
2.	_____	_____	_____	6.	_____	_____	_____
3.	_____	_____	_____	7.	_____	_____	_____
4.	_____	_____	_____	8.	_____	_____	_____

☐ If willing to supply our products to any **re-seller or sub-dealer**, **(**Functional Ortho braces e.g. OA, Spinomed etc., shall be supplied only if re-seller / Sub-dealer have completed the Professional Training from PMIPL**)** - Please fill-up the following**:**

Sl.	Name Of Re-Seller / Sub-Dealer	Address / Area	Sl.	Name Of Re-Seller / Sub-Dealer	Address / Area
1.	_____	_____	3.	_____	_____
2.	_____	_____	4.	_____	_____

☐ **DECLARATION FROM PROFESSIONAL P&O ☐ OR PHYSIOTHERAPIST ☐ - OPTING FOR DEALER / DISTRIBUTORSHIP**
(Stamped & Signed by **PO's / PT's** with their **RCI / IAP Regd. No's)**

I / We being the Professional with already having experience in proper application & dealing in the similar product of the company mentioned as under**:**

- **ORTHO braces: OA** _____**; Spinal** _____
- **PROSTHETIC Items: Foots** _____**; Joints** _____**; Liner** _____

Since we have not taken the Professional training, although offered and to avoid any confusion or misunderstanding in future, as we are capable to do the fitment by our own, we wish to inform that Pushpanjali shall not be responsible for any product complaint or adverse impact on patient arising post fitment (application) of the Product.

❖ **Explanation made : Terms & Condition of Proposed Distributorship Agreement :** ⟶ Yes ☐ / No ☐

Please note, in case, more Hospitals or Doctors are required to be added in future, please inform in advance and take prior consent for the same

❖ **Remarks :** _____

_____

_____	_____	_____
Date	**Signature Of PMIPL Representative**	**Signature of Distributor's/ Dealer's Representative with (RCI/IAP Regd.No, if applicable) Stamp**