PATTERSON®

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KNOW YOUR CUSTOMER QUESTIONNAIRE

Important: Know Your Customer (KYC) Questionnaire will not be processed unless all questions are completed. This refers to both controlled substances and List 1 chemicals. This form should be completed by the DEA registrant when possible; however, in the event that the registrant does not complete the form, the registrant must review and approve the completed form prior to submission. Patterson has the exclusive right to refuse to ship any controlled substance order for any reason.

SECTION 1 – GENERAL INFORMATION

1	Practitioner Name (as it appears on the DEA registration):						
2	Practitioner DEA registration number:						
3	Practice/clinic name:						
	Street:				Phone*:		
	City:				Email*:		
	State:		ZIP Code:		Website:		☐ N/A
4	Days and Hours of Operation:						
	**DEA registrant information. The contact information will not be used for marketing purposes. This information will be used for customer outreach questions regarding controlled substance orders.*						

5	Name of primary practitioner/researcher:	
6	Number of primary practitioners/researchers at registered location:	
7	Of the above practitioners, how many individuals possess a DEA registration?	

8	Practice Type (select all that apply):							
	☐ Traditional	☐ Mobile	☐ Emergency	☐ Research*	☐ University	☐ Shelter	☐ Government	☐ Other
	*If Research, please attach a copy of approved research protocol and specify scope of research and type of research subjects (i.e., mice, swine, nonhuman primates, etc.):							
	Patient Type (select all that apply):							
	☐ Companion Animal	☐ Equine	☐ Mixed	☐ Other:				

9	Select the reason you are completing this form (select one only):	
	☐ New business/practice	
	☐ Established business adding Patterson as a supplier	
	☐ Established business adding a new facility	
	☐ Established business replacing existing supplier with Patterson as new supplier	
	☐ Existing customer changing address - identify account #:	
	☐ Existing customer changing DEA practitioner - identify account #:	
	☐ Existing customer with change in ownership - identify account #:	
	☐ Other reason – describe and if applicable identify account #:	

10	Ownership Type:			
	☐ Sole Proprietor	☐ Partnership	☐ Corporation	☐ Other:
	Where there are multiple owners, identify percentage of ownership for each. Total must equal 100%			
	Owner name	If licensed practitioner, list all federal/state licenses	State of residence	% of ownership

SECTION 2 – LICENSES

11	DEA registrant state licenses/registrations and all applicable facility state licenses/permits*:	
	Type	Number
	**This includes any separate state-controlled substance license/registration, or a facility permit such as a Florida HCCE permit, Ohio TDDD license, VA Veterinary Establishment Permit, etc.*	

SECTION 3 – SANCTIONS/DISCIPLINE

12	To your knowledge, is DEA registrant or any owner/practitioner/employee currently under investigation by any licensing authority, including DEA? If yes, please explain. (when, why, etc.)	☐ Yes	☐ No
13	Has the DEA registrant or any owner/practitioner/employee had a license or registration denied, revoked, or suspended by any licensing authority, including DEA? If yes, please explain. (when, why, etc.)	☐ Yes	☐ No
14	Has a supplier ever suspended or ceased controlled substance sales to the entity? If yes, please explain. (when, why, etc.)	☐ Yes	☐ No
15	Does the practice comply with Federal and State laws in every state in which it purchases, stores, and dispenses Pharmaceutical and Controlled Substances? If no, please explain. Attach a separate sheet if necessary.	☐ Yes	☐ No

SECTION 4 – CONTROLLED SUBSTANCE PURCHASES

16	Identify individuals the DEA registrant has duly authorized to order, receive, and handle controlled substances. DEA registrant Included.					
17	Are any individual(s) other than the DEA registrant authorized to execute Forms 222?				☐ Yes	☐ No
	If yes, please identify the individual(s) below and, for each, provide a copy of an executed Power of Attorney granting such authority.					
18	Average number of patients/research subjects/other **per day**:					
19	Average number of patients/research subjects/other **per day** that are treated with controlled substances (whether dispensed, administered or prescribed):					
20	Average number of patients/research subjects/other **per day** that are treated with non-controlled substances, prescription drugs (whether dispensed, administered or prescribed):					
21	In an average month, when you order drugs for your practice, what percentage are: (total percentage must equal 100%):					
	Controlled substances and/or List 1 chemicals:				% of total purchases	
	Non-controlled substances/prescription only:				% of total purchases	
	Over the Counter/Non-prescription:				% of total purchases	
22	How often are controlled substances ordered?	☐ Daily	☐ Weekly	☐ Monthly	☐ Annually	☐ Other
23	Do you purchase controlled substances from suppliers other than Patterson?				☐ Yes	☐ No
	If yes, please identify all suppliers you have used during the previous 12 months:					
24	Do you anticipate continuing to purchase controlled substances from the above suppliers in the next 12 months?				☐ Yes	☐ No
25	Identify the top three controlled substances that you most frequently dispense, administer, or prescribe. Different dosages of same active ingredient will not be accepted. Please list 3 separate controlled substances.					
26	Methods of payments the practice receives for controlled substances. Total must equal 100%.					
	Cash:		% of total purchases	Credit:		% of total purchases
	Other:		% of total purchases	If other, please specify method in detail below:		
27	Percentage ratio of in-state versus out-of-state patients. Total must equal 100%.					
	In-state:			Out-of-state:		

SECTION 5 – ACKNOWLEDGEMENT

BY SIGNING BELOW, I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION CONTAINED HEREIN IS TRUE AND ACCURATE AND SUCH INFORMATION WAS EITHER: (A) ENTERED BY THE DEA REGISTRANT OR (B) REVIEWED AND APPROVED BY THE DEA REGISTRANT.

Name (print):		Title:	
Signature:		Date:	