***Please read carefully the information below outlining Americares Medical Outreach’s capabilities regarding Zimmer Biomet product donations for U.S. Charitable Surgeries.***

1. Americares will consider requests for the donation of Zimmer Biomet products to U.S. licensed physicians performing surgeries in the U.S and for patients who qualify for charitable assistance based on the standards used by the hospital in which the surgery will take place. By signing this agreement, the physician is confirming that the patient meets those standards.
2. Neither the patient, a family member, insurance company, nor a federal, local, or state program, nor any other third party payer will be charged for the surgery and/or services performed in conjunction with the surgery.
3. **All requests for Zimmer Biomet product donations for U.S. charitable surgeries must be pre-approved by Americares prior to the surgery. We cannot approve any product donations for surgeries that have already taken place.**
4. To avoid HIPAA conflicts, please do not provide Americares with specific information regarding the patient other than gender, age and country of citizenship as requested on the application unless the patient is willing to have his/her story publicized (see last page of application). Americares has no interest in the patient’s legal resident status and only uses country of citizenship for our general demographic data.
5. The physician must provide Americares with a detailed description of the type of surgery s/he will be performing, as well as the complete product numbers for and quantities of the products that s/he anticipates using for that surgery. In most cases, actual products to be used will be determined in the operating room and substitutions for sizes and/or similar products are permitted.
6. Requests for donated products must be pre-approved by Americares, usually working in conjunction with the physician’s Zimmer Biomet sales representative. In most cases, the sales representative will bring all approved products to the operating room for the surgery. In cases where a sales representative is not involved, it is the responsibility of the physician and/or medical facility to ensure that the products are available in the operating room. Americares is not involved with providing the actual products and has no liability whatsoever in this regard.
7. Upon completion of the surgery, the sales representative (or medical facility/physician if applicable) will fax or email to Americares a copy of the **operating room** **sticker list that includes the hospital patient sticker showing the surgery date and the surgeon’s name and** **that has been signed by the surgeon. Please remove or block out patient health information.** A clear cell phone photo is acceptable. Americares will review the products used and, assuming there are no major unexplained discrepancies, will approve and process the charitable donation. Americares is not involved with Zimmer Biomet’s internal accounting or inventory procedures. For any questions about how the charitable donation is processed once approved, please contact Zimmer Biomet.
8. Given constraints on products available for donation, Americares anticipates limiting requests to enable a maximum of 2 patients per year per physician/organization/medical facility.
9. I agree to notify Americares immediately of any occurrence that has the potential to negatively impact Americares.
10. **I agree to fully indemnify, hold harmless and defend Americares, its directors, officers, employees and agents from and against all claims, demands, causes of action, lawsuits and any liability, costs and expenses (including reasonable attorney’s fees and costs) resulting from trip activities and/or usage of Americares provided product**.

I have read and agree to follow the terms as stated above:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **Physician’s Name:­­­­­­­** |  | **Physician's Signature** |  | **Date** |

***If completed electronically and returned via email, a typed signature is acceptable. If completed by hand, please write clearly, then print, sign and return the application by fax or email.***

**Please email (**[**medicaloutreach@americares.org**](mailto:medicaloutreach@americares.org)**) or fax 203-658-9510 completed paperwork to Americares.**

**For any questions, please email as above or call 203-658-9500 and ask for Medical Outreach.**

By completing and submitting this form, you affirm that you will personally oversee the use of and will take full responsibility for the Zimmer Biomet product donation approved by Americares. In compliance with Internal Revenue Service regulations, these products will be used for indigent patients only and will not be sold or exchanged for property or services.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Contact Information** | | | | | | | | | | | | | | | | | | |
| 1. | | Physician’s Contact Information | | | | | | | | | | | | | | | | |
|  | | Name: | | | | | | | Practice Name: | | | | | | | | | |
|  | | Street Address: | | | | | | | | | | | | | | | | |
|  | | City: | | | | | | | State (2-letter): | | | | | | Zip: | | | |
|  | | Email: | | | | | | | Telephone #:  Specify if Home  Work Cell Other | | | | | | | | | |
| 2. | | Zimmer Biomet Representative’s Contact Information | | | | | | | | | | | | | | | | |
|  | | Name: | | | | | | | Distributor: | | | | | | | | | |
|  | | Street Address: | | | | | | | Office Contact Name: | | | | | | | | | |
|  | | Office Contact Email: | | | | | | | | | |
|  | | City: | | | | | | | State (2-letter): | | | | | | Zip: | | | |
|  | | Email: | | | | | | | Telephone #:  Specify if Home  Work Cell Other | | | | | | | | | |
| 3. | | Medical Facility Contact Information (where surgery will be performed) | | | | | | | | | | | | | | | | |
|  | | Facility Name: | | | | | | | | | | | | | Account #: | | | |
|  | | Street Address: | | | | | | | | | | | | | | | | |
|  | | City: | | | | | | | State (2-letter): | | | | | | Zip: | | | |
|  | | Contact Name: | | | | | | | Contact Phone #: | | | | | | | | | |
| **Surgery & Patient Information** | | | | | | | | | | | | | | | | | | |
|  | Type of Surgery (full description): | | | | | | | | | | | | | | | | | |
|  | Date of Surgery: | | | Patient Age: | | | | Gender: | | | Country of Citizenship: | | | | | | | |
|  | Are the physician & patient willing to be interviewed and/or photographed for Zimmer Biomet’s & Americares publications? More information on last page. | | | | | | | | | | | |  | Yes  No  Unsure | | | | |
| **License Information** | | | | | | | | | | | | | | | | | | |
| License Type (MD, DO): | | |  | | License State (2-letter): | | | | |  | | Exp. Date: | | | | | |  |
| A copy of the Physician’s current U.S. state medical license is included with the application. | | | | | | | | | | | | | | | | | | |
| The Physician’s state no longer provides a hard-copy license. An online license verification and a copy of the Physician’s current driver’s license are attached instead. | | | | | | | | | | | | | | | | | | |
|  | | | | | |  |  | | | | | | | | |  |  | |
| **Physician’s Name:­­­­­­** | | | | | |  | **Physician's Signature** | | | | | | | | |  | **Date** | |

**Please email (**[**medicaloutreach@americares.org**](mailto:medicaloutreach@americares.org)**) or fax 203-658-9510 completed paperwork to Americares.**

**For any questions, please email as above or call 203-658-9500 and ask for Medical Outreach.**

**ZIMMER BIOMET PRODUCT REQUEST FORM**

* Please list by complete Zimmer Biomet product number, description and quantity the items to be used for the charitable surgery. Additional copies of this page can be utilized where necessary.
* Substitutions for sizes or similar products can be made in the operating room, so please choose only one representative product number for each component.
* If a choice might arise between two differently-priced products, list the higher-priced option on this form.
* The Zimmer Biomet Sales Representative (or Physician/Medical Facility, if applicable) is responsible for bringing all of the necessary products and instrumentation to the operating room.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PRODUCT NUMBER** | | | **DESCRIPTION** | | | | | | | | **UNIT** | **QTY** |
|  | | | **SAMPLE** | | | | | | | |  |  |
| 00-8890-002-00 | | | ORTHO CAST PADDING, 2 | | | | | | | | BX-20 | 1 |
| 65-6200-036-20 | | | TRILOGY ACET SHELL 36MM OD MULTI HA | | | | | | | | EA | 2 |
|  | | |  | | | | | | | |  |  |
|  | | |  | | | | | | | |  |  |
|  | | |  | | | | | | | |  |  |
|  | | |  | | | | | | | |  |  |
|  | | |  | | | | | | | |  |  |
|  | | |  | | | | | | | |  |  |
|  | | |  | | | | | | | |  |  |
|  | | |  | | | | | | | |  |  |
|  | | |  | | | | | | | |  |  |
|  | | |  | | | | | | | |  |  |
|  | | |  | | | | | | | |  |  |
|  | | |  | | | | | | | |  |  |
|  | | |  | | | | | | | |  |  |
|  | | |  | | | | | | | |  |  |
|  | | |  | | | | | | | |  |  |
|  | | |  | | | | | | | |  |  |
|  | | |  | | | | | | | |  |  |
|  | | |  | | | | | | | |  |  |
| **Your signature below will confirm that the products listed above have been:**   * carefully reviewed * will be used for indigent patients only * will not be sold or exchanged for property or services | | | | | | | | | | | | |
|  | | | |  |  | | | |  |  | | | |
|  | | | |  |  | | | |  |  | | | |
| **Physician’s Name** | | | |  | **Physician's Signature** | | | |  | **Date** | | | |
|  | | | | | | | | | | | | |
| **Hospital:** | |  | | | | | | **Account #:** | | | | |
| **Surgery Date:** | |  | | | | | | | | | | |
| **Zimmer Biomet Rep:** | |  | | | | | | | | | | |
| **SMS Case #:** | |  | | | | | | | | | | |
|  |  | | | | |  |  | | | | |  |

**Please email (**[**medicaloutreach@americares.org**](mailto:medicaloutreach@americares.org)**) or fax 203-658-9510 completed paperwork to Americares.**

**For any questions, please email as above or call 203-658-9500 and ask for Medical Outreach.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Please Help Us to Publicize This Program** | | | | | | |
| We are interested in sharing some stories to highlight the U.S. Charitable Surgery Program to provide help for people in need in the U.S. Would you and your patient be amenable to sharing your story and providing a photograph of the two of you? Stories would be used by Zimmer Biomet both internally with employees to increase awareness of the program and externally with the local media in your area. Americares may also use the stories in our print or online publications. There is no obligation and we want to observe all HIPAA regulations, but thank you for considering it—it is very helpful to Zimmer Biomet, the physicians and their patients to be able to get the word out about this donation program. | | | | | | |
| Patient’s permission to share his/her story:  Yes  No | | | Patient’s Name (either full name or first name/last initial if patient prefers): | | | |
| Patient’s Diagnosis: | | | Surgery Performed: | | | |
| Physician’s Name: | | | Orthopedic specialty (if any): | | | |
| How did the Americares U.S. Charitable Surgery Program help make the surgery possible? | | | | | | |
| Quote from physician on his experience with the Americares U.S. Charitable Surgery Program: | | | | | | |
| Quote from patient about how having access to this program and free surgery changed his/her life: | | | | | | |
| Photo of physician with patient, pre-surgery, post-surgery or both. Please email high-resolution photos in jpeg format to [medicaloutreach@americares.org](mailto:medicaloutreach@americares.org) | | | | | | |
| **Suggested Contribution** | | | | | | |
| We ask you to consider a suggested contribution of $250 or more to help offset the administrative costs of providing this program. Neither the amount nor the contribution itself is obligatory, but we thank you in advance for your support that allows us to offer this service to you and others. All contributions are tax-deductible and a receipt will be provided. | | | | | | |
| **To Make a Credit Card Donation Online**:  Go directly to the donation page at <https://secure.americares.org/site/Donation2?df_id=6120&6120.donation=form1>  Or go to the Medical Outreach Exchange at <http://medicaloutreach.americares.org/> and click the “Donate” button. | | | | | | |
| **To Make a Credit Card Donation by Phone**: Please call 203-658-9528. | | | | | | |
| **To Mail a Check**: Please mail to Americares, **Medical Outreach**, 88 Hamilton Avenue, Stamford, CT 06902. | | | | | | |
| **To Make a Credit Card Donation with this Application**: complete the required information below. | | | | | | |
|  | | | | | | |
| In order to help defray Americares Medical Outreach administrative costs, I am making a donation in the amount of $       (suggested: $250). I authorize you to charge my credit card as follows: | | | | | | |
| **Cardholder Name:** |  | | | **Type of Card: (VISA, AMEX, MC, etc)** | |  |
| **Card Number:** |  | | | **Expiration Date:** |  | |
| **Billing Address:** |  | | | **City, State, Zip:** |  | |
| **Billing Tel.#:** |  | **Signature:** | | | | |
| **Disclosure**  A copy of Americares’ latest financial statement and form 990 filing may be obtained by contacting Americares. If you are a resident of one of these additional states, you may obtain financial information or annual report from us or directly from your state’s relevant agency: In **New York**: Office of Attorney General, Charities Bureau, 120 Broadway, New York, New York 10271 \* In **Maryland**: Secretary of State, State House, Annapolis, MD 21401 \* In **New Jersey**: Attorney General, (973) 504-6215 \* In **North Carolina**: Department of the Secretary of State, 1-888-830-4989 \* In **Pennsylvania**: Department of State at 1-800-732-0999 \* In **West Virginia**: Secretary of State, State Capitol, Charleston, WV 25305 \* In **Virginia**: State Division of Consumer Affairs, P.O. Box 1163, Richmond, VA 23209 \* In **Washington State**: Secretary of State, 1-800-332-4483 \* In **Florida**: Division of Consumer Services at 1-800-435-7352 *(Our Florida Registration number is SC-00910 and since Americares does not employ professional solicitors, we retain 100% of contributions and 0% is retained by such solicitors)* \* In **Michigan**: Our license number is 10588 \*In **Kansas**: Office of Secretary of State, First Floor, Memorial Hall 120 S.W. 10th Avenue Topeka, KS 66612-1594 (Our registration #222F593F6SC). Copies of the filings with the authorities listed above can also be obtained by writing to Americares at 88 Hamilton Ave., Stamford, Connecticut 06902. Registration with any of the above agencies does not imply endorsement by the state. | | | | | | |