



MEDICAL PROVIDER AGREEMENT

Name _____ Email _____

License No. _____ License Type _____ State _____

Practice Name _____

Medical Specialty _____

Address _____

Phone No. _____ Fax No. _____

Shipping Address (if different from above) _____

Online Ordering (please create the following)

Provider Username _____ Provider Password _____

How many weight-loss patients do you anticipate treating per week? (check one)

1-5

6-10

>10

I understand that it is the responsibility of the medical practitioner and his/her practice to manage all elements of the Medifast Program including ordering, receiving, and distributing products. I agree to comply with all applicable state regulations and laws, to provide clinical Medifast services in an ethical manner according to the guidelines provided in the Program Manual, to fairly represent Medifast, to use Medifast logos and trademarks following the guidelines of Medifast, and to immediately cease using all Medifast materials, logos, and trademarks should I cease to be a Medifast provider.

I understand that medical practitioners are prohibited from selling, auctioning, or attempting to sell Medifast products, programs, or promotional materials on the Internet or from a retail location that markets prominently under the Medifast trademark without expressed written consent from Medifast, Inc. I understand that either Medifast or I may terminate this agreement at any time, for any reason, with 10 days written notice.

Medical Provider Signature

Date

Please mail or fax completed Medical Provider Agreement to:

Professional Services
11445 Cronhill Drive,
Owings Mills, Maryland 21117
(443) 471-3346 Fax