720 SW Washington Street, Suite 200 Portland, OR 97205-3504 USA
TEL: +1.503.245.0459 FAX: +1.971.223.1000 WEB: www.tricolbiomedical.com

Date: ____/____/____ Rev. 11-2017

DISTRIBUTOR PROFILE

Basic Profile

Company Name: ______________________
Contact Name: ______________________
Contact Title: ______________________
Address: ______________________
City / State / Zip: ______________________
Country: ______________________
Phone: ______________ **Fax:** ______________
Email: ______________ **Website:** ______________

Number of Employees (in Territory):

Total: __________ **Outside Sales:** __________ **Inside Sales:** __________

Approximate annual sales in U.S. dollars (check one):

☐ <$500,000 ☐ $500,000 - $1M ☐ $1M - $5M ☐ $6M - $10 M ☐ $11M - $25M ☐ >$25M

Approximate number of Products you represent / sell:

Do you stock product: ☐ YES ☐ NO

☐ **Please provide a powerpoint presentation of your company when returning this form.**

In which country or countries do you currently sell into and what percent of your sales are in each territory?

Territory	% Sales	Sub-Dealers (Yes/No)

What are your Company's Target Markets? (*List from strongest (1) to weakest (5), use NA if not involved*):

Government/ Military ______ **Pre-Hospital** ______ **Hospitals** ______ **Home Health / LTC** ______ **Surgery Centers** ______ **Other (specify)** ________

If you market to hospitals, which areas below are primary (P) or secondary (S) focus / call points:

_____ Interventional Cardiology
_____ Interventional Radiology
_____ Dialysis
_____ Operating Room / Theater (Surgical specialty:_____)
_____ Emergency Department
_____ Infection Control
_____ Wound Care
_____ Intensive Care
_____ Other: _____

Please list the names of each manufacturer and their product(s) you currently represent:

Do you currently sell any other hemostasis or infection control products? If yes, please list:

Please explain your strengths as a distributor below compared to your competition.

Please list your sales and marketing activities and programs you utilize.

Is regulatory clearance required for sale in your territory and though which entity?

☐ Yes Name of Regulatory Body: ☐ No

Do you have regulatory product registration resources?

☐ Yes ☐ We contract these services locally ☐ No

Have you ever successfully registered a US product in your country?

☐ Yes ☐ No

Please explain the regulatory environment in your country/countries, including estimate number of months it will take to register the HemCon Product(s):

Which Quality Management system do you have in place?

☐ ISO 9001 ☐ ISO 13485 ☐ Other, please explain:

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☐ **None, please explain:**

References

Please provide us with two business references, such as your financial institutions, business partners, manufacturers, and suppliers:

Business Reference 1: **(this reference should be able to verify your financial dependability)**
Company Name:
Address:
City: **State:** **Zip:** **Country:**
Contact Name: **Contact Email:**
Contact Title: **Contact Phone:**
Contact Fax:

Business Reference 2: **(this reference should be able to verify your capabilities to move product)**
Company Name:
Address:
City: **State:** **Zip:** **Country:**
Contact Name: **Contact Email:**
Contact Title: **Contact Phone:**
Contact Fax:

Please provide us with three customer references that we may contact as part of our due diligence:

Customer Reference 1:
Company Name:
Address:
City: **State:** **Zip:** **Country:**
Contact Name: **Contact Email:**
Contact Title: **Contact Phone:**
Contact Fax:

Customer Reference 2:
Company Name:
Address:
City: **State:** **Zip:** **Country:**
Contact Name: **Contact Email:**
Contact Title: **Contact Phone:**
Contact Fax:

Customer Reference 3:
Company Name:
Address:
City: **State:** **Zip:** **Country:**
Contact Name: **Contact Email:**
Contact Title: **Contact Phone:**
Contact Fax:

Credit Evaluation

Dun & Bradstreet #:

Business Type: ☐ **LLC** ☐ **Private Limited Liability** ☐ **Public** ☐ **Other;**

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BIOMEDICAL INC

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Number of Years Trading:

****

Credit Manager Approval (internal only):

Payment Terms: ☐ **Prepayment** ☐ **Net 30** ☐ **Net 60**

Please send this form to Tricol Biomedical Customer Solutions Department:
Fax +1.971.223.1000 or Email: info@tricolbiomedical.com