

**MAGNET COOPERATIVE ("MAGNET")
HAUSTED PATIENT HANDLING SYSTEMS, LLC
Participation/Designation – Letter of Commitment**

MAGNET Member(s) _____
(Please attach listing of facilities)

Address _____

City/State/Zip _____

Telephone Number _____ Fax Number _____

HIN _____ GLN # _____

The above-named MAGNET Member(s) agrees to the following:

Specifics addressing member requirements should be included in this section including distribution specifics as required. For Example:

The above-named MAGNET Cooperative Supply Chain Systems Member designated MAGNET as its primary Group Purchasing Organization

Select One: Distribution -or- Direct

Authorized Distributor _____

Branch Location (City/State) _____

MAGNET COOPERATIVE MEMBER

Authorized Signature _____

Print/Name/Title _____

Date _____

Return to: Commitment Form Coordinator
 MAGNET Cooperative
 4823 East Trindle Road, Suite 300
 Mechanicsburg, PA MO 17050
 FAX: 717/763-7464
 www.magnetgroup.com

