

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935

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1400 E. Washington Avenue
Madison, WI 53703

E-Mail: web@dsps.wi.gov
Website: http://dsps.wi.gov

DIVISION OF PROFESSIONAL CREDENTIAL PROCESSING BOND OF PRESCRIPTION DRUG WHOLESALE DISTRIBUTOR

POLICY NUMBER _____

KNOW ALL PERSONS BY THESE PRESENTS

That _____
(Printed Name of Individual or Entity Checked at the Right)

- an sole proprietorship
- a partnership
- a corporation
- a limited liability company

doing business as _____
(Printed Trade Name, If Applicable)

at _____, as PRINCIPAL, and
(Address of Wholesale Distributor)

_____, of
(Printed Name of Surety)

_____, as Surety,
(Address of Surety)

a corporation duly authorized to do business in the State of Wisconsin, are held and firmly bound unto the Obligees of the bond to make payment of the sum of Five Thousand Dollars (\$5,000). We, the PRINCIPAL and the SURETY, bind ourselves, firmly by this bond, provided that no obligation hereunder shall require payment more than once for the same loss or damage. The Condition of the Obligation is such that the PRINCIPAL has applied for issuance of licensure to do business as a prescription drug wholesale distributor pursuant to section 450.071, Wisconsin Statutes, and applicable sections of the Wisconsin Administrative Code. The purpose of this surety bond is to secure payment of fees or costs that relate to the issuance of a license under section 450.71, Wisconsin Statutes, and that have not been paid within 30 days after the fees or costs have become final. If the Principal or any of its employees, agents, or representatives by whatever name they might be known cause payment of fees or costs that relate to the issuance of a license under section 450.071, Wisconsin Statutes, within 30 days after the fees or costs have become final during the term of this bond, then this Obligation is void, but otherwise of full force and effect for the benefit of the State of Wisconsin.

1. The term of this bond shall be from the date of its signing by Principal and Surety for the entire period of an unexpired prescription drug wholesale distributor's license issued to the licensee or until the Surety exercises its right of termination pursuant to Paragraph 2 below. A claim may be made against this bond up to one year after the date on which the prescription drug wholesale distributor's license expires or the bond is terminated.

2. Surety reserves the right to terminate this bond at any time, such termination to be effected by Surety's giving sixty (60) days written notice, by certified mail to: The Principal and the Wisconsin Department of Safety and Professional Services, Office of Legal Counsel, 1400 East Washington Avenue, Madison, WI 53708-8935, ("DSPS"). The liability of Surety on this bond shall cease sixty (60) days after receipt of the termination notice by DSPS and Principal, or on the filing and acceptance of a new bond whichever first occurs; and the bond shall terminate and be of no further force or effect, except as to any liability, debt, or other obligation incurred or accrued prior to the effective date of such termination.

Signed and sealed this _____ day of _____, _____

(Principal)

(Witness) By: _____
(Title)

(Surety)

By: _____
(Attorney in Fact)

(Note: Attach to this Bond a properly certified copy of the Agent's Power of Attorney.)

#2819 (Rev. 9/11)
Ch. 450, Stats.

Committed to Equal Opportunity in Employment and Licensing

Bond forms change; this is for educational purposes only.

SURETY BOND APPLICATION

AGENCY NAME: _____ AGENCY CONTACT _____
 AGENCY PHONE: _____ AGENCY FAX: _____ E-MAIL: _____
 AGENCY ADDRESS: _____
(Street) (City) (State) (Zip)

CURRENT OR EXPIRING QUOTE WE ARE LOOKING TO BEAT? _____
NAME OF PREVIOUS SURETY COMPANY WRITING THE BOND? _____

SECTION I: BOND APPLIED FOR:

TYPE OF BOND: _____ AMOUNT: _____
 OBLIGEE: _____ EFF. DATE: _____ EXP. DATE: _____

OBLIGEE ADDRESS: _____
(Street) (City) (State) (Zip)

BUSINESS NAME: _____

BUSINESS PHONE: _____ BUSINESS FAX: _____ Client E-mail _____

BUSINESS ADDRESS: _____
(Street) (City) (State) (Zip)

TYPE OF COMPANY CORP LLC DBA PARTNERSHIP HOW MANY OWNERS? _____

DATE BUSINESS ESTABLISHED: _____ BUSINESS TAX ID: _____

HAS ANY COMPANY REFUSED TO ISSUE BONDS FOR ANY PURPOSE? YES NO DO YOU HAVE ANY LIENS, CLAIMS, OR JUDGEMENTS AGAINST YOU? YES NO

HAS APPLICANT EVER FAILED IN BUSINESS? YES NO HAS APPLICANT EVER FILED BANKRUPTCY? YES NO

SECTION II: GENERAL INFORMATION

OWNER'S NAME: _____ SPOUSE NAME _____

SS#: _____ SPOUSE SS# _____ HOME PHONE: _____

RESIDENTIAL ADDRESS: _____
(Street) (City) (State) (Zip)

ADDITIONAL OWNERS / PARTNERS

OWNER'S NAME: _____ SPOUSE NAME _____

SS#: _____ SPOUSE SS# _____ HOME PHONE: _____

RESIDENTIAL ADDRESS: _____
(Street) (City) (State) (Zip)

PERSONAL FINANCIAL STATEMENT OF ASSETS & LIABILITIES AS OF _____

ASSETS		LIABILITIES	
CASH IN BANK	\$	NOTES PAYABLE TO BANKS	\$
CASH ON HAND	\$	NOTES PAYABLE TO OTHERS	\$
STOCKS & BONDS	\$	ACCOUNTS PAYABLE	\$
ACCOUNTS RECEIVABLE	\$	FEDERAL & STATE INCOME TAX DUE	\$
NOTES RECEIVABLE	\$	ALL OTHER TAXES	\$
INVENTORY	\$	ACCRUALS, PAYROLLS, ETC.	\$
CASH VALUE OF LIFE INSURANCE	\$	DUE ON EQUIPMENT	\$
EQUIPMENT	\$	DUE ON REAL ESTATE	\$
REAL ESTATE	\$	OTHER LIABILITIES	\$
OTHER ASSETS	\$	CAPITAL STOCK (IF A CORPORATION)	\$
		SURPLUS & UNDIVIDED PROFITS	\$
TOTAL ASSETS	\$	TOTAL LIABILITIES	\$
		NET WORTH	\$
NAME OF OWNERS	NAME & TITLE OF OFFICERS	PERCENTAGE OF OWNERSHIP	

Completion of this form constitutes permission for worldwide insurance specialists inc. to obtain consumer information which will be used to determine bonding eligibility.

Worldwide Insurance Specialists, Inc 2424 W. Missouri AVE Phoenix, AZ 85015 E-Mail SAM@WWISINC.COM	Toll Free: (888) 518-8011 Local (602) 749-0702 Fax: (602) 674-8235
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