

PROVIDER POWER OF ATTORNEY

I, _____, physician employed at _____ located at _____ (the “Health Center”) hereby appoint Alfredo Jones, solely in his capacity as Program Coordinator of Salud A Su Alcance Pharmacy Assistance Program (“SASA-PAP”) at New York Presbyterian Hospital (“NYP”), 622 West 168th Street, New York NY 10032, as my Attorney-in-Fact (“Agent”).

The purpose of designating the patient assistance program (PAP) advocate named above as my Agent to sign the PAP applications on my behalf is to expedite the process of PAP applications and reduce the wait time for my patients to access their donated medications.

My Agent shall have restricted authority to act on my behalf only to assist my patients with prescriptions that I prescribed to be processed for Patient Assistance Programs offered by various pharmaceutical companies. My Agent's powers shall include the power to:

1. Obtain the necessary information and documentations from my staff or my patient to complete PAP applications for prescriptions authorized by me.
2. Sign PAP application on my behalf for all participating pharmaceutical companies attesting to the accuracy of the information provided on the application.(Appendix I)
3. Sign Letters of Hardship to be sent to participating pharmaceutical companies when necessary (Appendix II)

Any power or authority granted to my Agent under this document shall be limited to patients under my care at the Health Center who wish to access donated prescription medications through NYP’s SASA-PAP program.

I authorize my Agent to indemnify and hold harmless any third party who accepts and acts under this document.

My Agent shall not be entitled to reasonable compensation for any services provided as my Agent. My Agent shall not be entitled to reimbursement of all reasonable expenses incurred in connection with this Power of Attorney.

My Agent shall provide an accounting for all prescriptions handled and all

Appendix II.

Provider's
First Name, Last Name, MD

16 E 16th St.
NY, NY 10003
(212) XXX-XXXX

July 13, 2007

Re: Patient's First Name Last Name

Dear Pharma. Co.,

The above referenced applicant is in my care. At the moment the patient is receiving assistance via generous donations from friends and family. The applicant currently has no reportable income. After having screened him/her, we are certain that he/she is eligible for the patient assistance program. Thank you for considering his/her enrollment application.

Respectfully,

Physician, M.D.
DEA# XX1234567
LIC# 123456