

PARTICIPATION AGREEMENT

THIS PARTICIPATION AGREEMENT ("Agreement") is made as of this _____ day of March, 2005, by and between **DOCTORS DIRECT OF THE C.S.R.A., INC.** ("IPA"), a Georgia corporation with an address of P.O. Box 12117, Augusta, GA 30914-2117, and the undersigned pharmacist.

RECITALS

WHEREAS, IPA produces a medical discount card known as the Doctors Direct Care Card ("Care Card") and wishes to engage the undersigned pharmacist as a Participating Pharmacist ("Pharmacist") in its published participating provider "network" and Pharmacist desires such engagement pursuant to the terms and conditions stated in this Agreement;

NOW, THEREFORE, in consideration of the mutual covenants herein contained, the receipt and sufficiency of which is hereby acknowledged, the parties, intending to be legally bound hereby, agree as follows:

1.1 Engagement. IPA does hereby engage the Pharmacist to provide "best practice" pharmacy services and the Pharmacist does hereby accept such engagement.

1.2 Compensation. Pharmacist agrees to accept, as payment in full, the then current Georgia Medicaid rates for prescription drugs or the Pharmacist's "cash" price (or Usual and Customary price), whichever is lower, whenever a Care Card holder receives pharmacy products from Pharmacist and such products are paid for by the Care Card member at the time such products are dispensed.

1.3 Term. This Agreement shall become effective on the date written above and shall continue until terminated as provided below. At all times, during the term of this Agreement, IPA shall have the right to publish the name and location of the Pharmacist's office and advertise same as a Participating Pharmacist.

1.4 Termination. This Agreement may be terminated by either party at any time, with or without cause, by written notification of intent to terminate delivered to the other party at least 60 days prior to such termination.

1.5 Assignability. Neither party shall assign, sell, lease or transfer this Agreement or any interest herein without the prior written consent of the other party.

IN WITNESS WHEREOF, the duly authorized officers of the parties hereto have hereunto affixed their hands and the respective seals of the corporations, as of the date first written above.

For **Doctors Direct of the C.S.R.A. Inc. :**

By:  _____ as President

For Pharmacist:

By: _____ Date: _____

Please attach multiple copies for multiple locations:

Your pharmacy information provided below will be published in the Provider Directory and on the Care Card web site. The information denoted with an asterisk () will not be published but will be retained for communication purposes. By listing your pharmacy's web site, your site will be linked to the Doctors Direct Care Card site (www.doctorsdirect-csra.com).*

Print Name (include suffix and title): _____

Pharmacy Name: _____

Pharmacy Address: _____

City/County/State/Zip: _____

Telephone: _____ ***Fax:** _____

***Email Address:** _____

Pharmacy Web Site: **www.** _____

Pharmacy License Numbers - Georgia: _____ **South Carolina:** _____

***Pharmacy Manager Name:** _____ ***Telephone:** _____

***Pharmacy Manager's Email Address:** _____