Clinical Information Network Membership Agreement

I, Dr……………………………………….of (office street address) ... ... ………………………. … … … … …

(City)……………... … … … … … … … … … … … … … (State)…………. (Zip code)……… … … … … …

whose ME number is as follows………………………. … … … … … … … … … … … … …, and

whose email address is ………………… …,

and telephone number is (……….. …… … …)… …,
AREA CODE

and cell phone number is (……….. …… … …)… ,
AREA CODE

and FAX number is (……….. …… … …)… …,
AREA CODE

wish to join the Clinical Information Network, and accept the following membership terms:

I understand that there is no charge or cost to me for joining the Network, and that I will be provided with the free use of a web camera and microphone together with a free download of Clinical Information Network's professional, HIPAA compliant, videoconferencing software, (referred to as the "Clinical InfoNet system"), that I may use, in accordance with the software licensing agreement accompanying the download, to conduct unlimited minutes of videoconferencing with other members of the Network in the United States or anywhere in the world, and that I will be provided with full technical support Monday through Saturday.

Also, I understand that as a member of Clinical Information Network I am entitled to establish my own professional videoconferencing network with my physician friends and colleagues, if I so wish, and to this end, Clinical Information Network agrees to provide web cameras, microphones, and downloads of the Clinical InfoNet professional software to any physician that I recommend, without cost to me or those physicians.

Furthermore, separate and distinct from the software downloads provided to my physician colleagues, as referenced above, if so requested, two additional software downloads of a more basic version of the videoconferencing software, may be provided to two other persons whom I wish to include in my network. However, I fully understand that Clinical Information Network will not be providing these additional users with web cameras or microphones. However, the software will be provided to them without cost.

Furthermore, I agree to install the provided web camera, microphone and software (obtaining free technical support from Clinical Information Network, should it be required) within FIVE business days of receipt, and, within FIVE business days from installation of the camera and microphone, I agree to initiate and participate in two video detailing sessions (live, onscreen, face-to-face meetings with a pharmaceutical sales representative) each week of a calendar month with two different pharmaceutical company clients of the Clinical Information Network. Further, I understand that Clinical Information Network confirms that no video detailing session will last more than 5 (five) minutes unless I express my willingness to extend the session. I agree that Clinical Information Network has no responsibility whatsoever for the statements made or material used, presented, or provided to me by such pharmaceutical companies or their representatives.

I agree that I, or Clinical Information Network, may terminate this Agreement at any time. Any such termination will terminate all rights to use the Clinical InfoNet System.

Signed………………………. … … … … … … … …

Dated…………………………... … … … … … … …

ACCEPTED and AGREED TO:

By: ______________________________________

For CLINICAL INFORMATION NETWORK, INC.

Please return fax TOLL-FREE to …

1-888-546-8964