



BUYER QUESTIONNAIRE

Date: _____ Name: _____

Pharmacist License Number: _____ State: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Questions Relating to Pharmacy Experience

Current Ownership _____ Ownership Experience (Years) _____ Management Experience (Years) _____

Available Capital: \$ _____ Need of Financing Support: _____ Geographic Area of Interest: _____

Acquisition Parameters

Minimum Revenue: \$ _____ Maximum Revenue: \$ _____ Preferred Square Footage: _____

Will a pharmacist need to be provided: yes no

Do you have a pharmacist to staff new acquisition: yes no

Preferred Hours of Operation: _____ Real Estate: Lease yes no Own yes no

Areas of Interest:

- Full Line Pharmacy
 - Professional Pharmacy
 - Clinic Pharmacy
 - Specialty Pharmacy
- (Please Specify): _____

Niches:

- Compounding
- Significant Long Term Care Business
- DME/HME Business

Please Check if Acceptable:

- Private Charge Accounts
- Delivery
- Mail Order
- Internet Pharmacy
- Nursing Home, Assisted Living, Unit Dose

Comments:

Please return completed form as an email attachment to: Maya@pcapartners.com OR fax it to: 877.758.6436.
Thank you!