**ATTACHMENT C (continued)**

Emergent Letter of Authorization

[MMCAP Infuse MEMBER LETTERHEAD]

[ADDRESS]

[CITY, STATE, ZIP]

[PHONE NUMBER]

[DATE]

Email to narcancustomerservice@ebsi.com

Emergent Devices Inc.

ATTN: Customer Service

401 Plymouth Road, Suite 400,

Plymouth Meeting, PA 19462

I, [PHYSICIAN, PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER NAME], am the responsible person for purchases made by [FACILITY NAME AND ADDRESS / IF MULTIPLE: PLEASE LIST ALL NAMES AND ADDRESSES] under my state license number [INDICATE STATE LICENSE #]) issued by the State of [INDICATE STATE NAME]

I will notify Emergent Devices, Inc. immediately if my responsibility status and/or relationship with this facility is changed or terminated.

[PHYSICIAN, PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER SIGNATURE]