International Container Shipment

Application A

Dear Friend,

Thank you for your interest in our international shipping program. This letter will provide very important information to help you understand and expedite World Medical Relief's (WMR) application process.

1. If a question does not apply, please explain why. Any unanswered questions or lack of documentation may result in the return of the application or denial of the request. When necessary, you may add pages to complete an answer, making reference to the question number.
2. Everything must be in ENGLISH. We do not provide translation.
3. ***There must be a contact person who is responsible for working with our personnel including making arrangements for the shipment.***

Once the **completed** application is received our Distribution Committee will review it. You will be notified of the approval or denial. The Director of International Programs will arrange with your contact person for the details and date of shipment.

The following list identifies the various costs associated with the shipment:

1. WMR's handling fee, which is identified on the last page of this package. **If your application is approved, it must be paid prior to the shipment.**
2. The shipping company's fee. You or your contact person will be responsible for paying this fee directly to the shipping company. WMR will not be involved in that transaction.
3. A charge of $250 per week may be assessed if we are required to hold the container until an inspector approves the shipment.
4. A $100 packing fee may be assessed if we have to repack the pallet/gaylord boxes.

We look forward to possibly working with your organization and we hope that these guidelines assist you in completing the application. If you have any questions please give us a call.

Sincerely,

George V. Samson
President & CEO

World Medical Relief - Container Shipment Application

1. Name of Recipient _____

A. Legal address of recipient

Street _____

City_____ Province _____

State _____ Country _____

B. Type of Institution (Please Specify)

Hospital _☐_ Clinic _☐_Other _____

C. Legal Status of the Institution: Public _☐_ Private _☐_

D. Name and license number of chief medical or dental officer

Name _____ID #_____

Address _____

City, State, Province, Country _____

Telephone (country code/area code & number) _____

E-mail address (if available)_____

E. Name and title of individual or person in charge of the recipient organization:

Name_____

Address _____

City, State, Province, Country _____

Telephone (country code/area code & number) _____

E-mail address (if available)_____

F. The locality for the request is: Rural area ☐ Urban area ☐

Other (specify) _____

G. Are services provided to the community free of charge?

Yes ☐ No ☐ Sliding Scale ☐ If the answer is "no", please explain what is paid and how this cost is determined

_____

H. Electricity – Is there any available? Yes ☐ No ☐ If yes, VOLTAGE _____ CYCLES _____. The electrical equipment we usually supply is 110 volts. Recipients will be responsible for voltage conversion, if any.

2. Please indicate the ten (10) leading cases diagnosed in the facility:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

9. _____ 10. _____

3. The Following Documentation Is Required In Order For This Application To Be Processed:

A. Copy of the Certificate of Registration or proof as a recognized health facility or state on a separate paper if this is not a requirement of the country.

B. Customs Duty Exemption **or** Letter of Responsibility of Fees Agreement (See attached sample of Letter of Responsibility)

C. Copy of license/diploma of the physician in charge of the Institution

4. <u>List Of Needs:</u> Please provide a separate list of the recipient's needs – **not** WMR's list of available items. **WE MAY NOT BE ABLE TO SUPPLY ALL THE ITEMS YOU REQUEST. WE RESERVE THE RIGHT TO DELETE, SUBSTITUTE OR ADD ITEMS. PLEASE BE AS SPECIFIC AS POSSIBLE WHEN LISTING MEDICAL EQUIPMENT.**

5. **Description Of Your Facility Or Program.** *If this request is for more than 1 hospital/clinic, please attach a separate sheet to answer parts "b" and "c" for each hospital/clinic*

A. 1. Is this request for a hospital? Yes ☐ No ☐

a.) How many hospitals? _____

b.) List the name and address for each hospital and administrator.

c.) Total number of beds in the hospital _____

B. 1. Is this request for a clinic? Yes ☐ No ☐

a) How many clinics?_____

b.) List the name and address for each clinic and administrator.

c.) Total number of beds in the clinic _____

Please indicate how you came to know about World Medical Relief. Please give the name, address, and telephone number with area code, of person or organization who referred you to World Medical Relief.

****

For Internal Purposes

APPROVED_____ DATE_____ DENIED _____ DATE_____

By:_____

WORLD MEDICAL RELIEF, INCORPORATED
POLICY FOR DISTRIBUTION OF DRUGS, MEDICAL SUPPLIES AND EQUIPMENT

Preamble: World Medical Relief operates exclusively for charitable purposes, through the receipt of contributions of cash and other properties, including medical and dental supplies, equipment, instruments and pharmaceuticals; and through the purchase of such items when required. It distributes these items in developing countries for the benefit and relief of financially impoverished persons throughout the world in a nondiscriminatory fashion without regard to geography, race, color, creed, gender, age, nationality or political beliefs.

1. United States National and Foreign Programs:

A. World Medical Relief shall distribute pharmaceuticals to approved non-profit organizations who distribute such items under the direction of licensed civilian doctors to financially impoverished persons.

B. World Medical Relief shall distribute medical and dental supplies and/or equipment to approved non-profit organizations who distribute such items under the direction licensed civilian doctors, nurses or paramedics to financially impoverished persons.

C. World Medical Relief shall distribute pharmaceuticals, medical supplies and/or equipment to approved non-profit organizations, individuals or groups who agree in writing that such items will be distributed by them in accordance with pharmaceuticals, equipment and supply policies 1.A. and B. of World Medical Relief. Such parties shall furnish written requests for pharmaceuticals, medical and dental supplies, and equipment needed by such parties prior to shipment of same by W.M.R. Following delivery of said items, the party receiving such goods shall send a written receipt to W.M.R.

2. Local Program:

World Medical Relief distributes to the financially impoverished residing in the area serviced by United Way Community Services and other areas approved by the Board of Directors of World Medical Relief within the State of Michigan. Prescriptions, medical equipment, and supplies are given, providing that the individuals residing within such service areas shall meet the requirements set by the Board of Directors of World Medical Relief.

3. General:

A. Shipments: World Medical Relief shall make no shipments for any person or group that has not originated at its warehouse, nor shall World Medical Relief do any crating for any person or group of their items for their shipping.

B. Donation of pharmaceuticals, equipment and supplies: World Medical Relief does not accept any donations of equipment, instruments, supplies, pharmaceuticals or other items that are designated for a specific person or place. All donations as above listed must be unrestricted.

I have read the above policy for distribution of pharmaceuticals, medical supplies and equipment as outlined by World Medical Relief, Inc. and agree to abide by it.

DATE _____ SIGNED _____

TITLE_____

This form must be signed by the individual in charge of the recipient organization – not by the sponsor.

WORLD MEDICAL RELIEF, INC.

RELEASE/HOLD HARMLESS/INDEMNIFICATION AGREEMENT

The undersigned, in consideration of World Medical Relief, Incorporated providing us with supplies, medical equipment and other medical support, agree:

1. To release World Medical Relief, Inc. from any and all claims made against the undersigned, as a result of the use, misuse or any application of the product or services provided by World Medical Relief, Inc.

2. To hold World Medical Relief, Inc. harmless from any and all costs, claims, actions including by not limited to actual attorneys fees, judgments or other claims which may be brought by any party, person(s) or individuals from the use, misuse or any application of the supplies or services provided to the undersigned by World Medical Relief, Inc.

3. To indemnify in full, including all attorneys fees, expenses, out of pocket costs and other costs of any kind, type or nature which World Medical Relief, Inc. may become liable for as a result of the undersigned's use, misuse or application of any kind, type or nature for the services or supplies provided to the undersigned by World Medical Relief, Inc.

_____ _____

Signature Date

_____ _____

Please Print Name Title or Position

****NOTE: This form must be signed by the person in charge of the recipient organization – not by the sponsor.****

WORLD MEDICAL RELIEF, INC.

OBLIGATIONS OF THE RECIPIENT INSTITUTION

A. To confirm the inventory of the donation by signing the **DONATION-ACKNOWLEDGEMENT FORM** which is included in the shipping documents. This form to be returned to WMR within one month.

B. To share with WMR any photographs or press releases which might promote future program activities. In addition, we may require pictures of the facilities during operating hours.

C. To inform World Medical Relief of the condition of the shipment, i.e. any damage or missing items within one month of receipt.

D. To receive representatives of WMR who will verify the condition and/or use of the donated equipment and supplies.

E. To recognize that the items requested are for charity use only and are not to be sold or bartered.

_____ _____

Signature Date

_____ _____

Please Print Name Title or Position

IF AN ORGANIZATION IS UNABLE TO COMPLY WITH THE OBLIGATIONS LISTED ABOVE, ASSISTANCE TO THEM MAY BE TERMINATED AS A RESULT.

****NOTE: This form must be signed by the person in charge of the recipient organization – not by the sponsor.****

WORLD MEDICAL RELIEF, INC.

SPONSORING INSTITUTION/INDIVIDUAL

1. Name Of Sponsoring Institution/Individual_____

   A. Legal address of sponsoring institution/individual

      Street _____

      City _____ Province _____

      State _____ Country _____

      Telephone (country code/area code & number) _____

      E-mail address (if available)_____

   B. **United States/Canadian Contact Person To Coordinate Shipment:**

      Name _____

      Street _____

      City, State, Zip_____

      Telephone _____

      E-mail address _____

2. **The Following Documentation Is Requested Regarding The Sponsoring Organization.** (Not Applicable for individuals.)

   A. Name of the organization:_____

   B. Contact person/representative:_____

      Address:_____

      _____

      Telephone number: _____

C**. If the organization is not a recognized institution or is a newly registered entity, please provide the following**:

A. Articles of Incorporation/partnership papers

B. Rules and/or by-laws of organization

C. Copy of tax-exempt status of organization

D. List of Board Members with their business affiliations

3. Shipping Arrangements – After approval, your United States/Canadian contact person will be required to make shipping arrangements with World Medical Relief and a designated freight forwarder. No other freight forwarder can be used aside from WMR's approved designated steamship line.

4. **Payment of costs.** A letter **MUST ACCOMPANY THIS APPLICATION** from the individual or organization stating responsibility for shipping costs and World Medical Relief's service fees. All service fees must be paid to WMR and shipping charges directly to the designated freighter company prior to shipping.

5. A detailed packing list/documentation will be forwarded to the United States/Canadian contact person after the loading of each container.

LIST OF TYPICAL
HOSPITAL EQUIPMENT AND SUPPLIES

ADULT SCALE
AMBULANCE CART
ARRHYTHMIA MONITORS
AUTOCLAVES
BASSINET – ISOLATION CRIB, JR. BEDS
BEDS – MANUAL/ELECTRIC
BEDSIDE TABLE/OVER-THE-BED
BILIRUBINMETER
BLOOD PRESSURE WITH STAND
BREATHING THERAPY UNIT
CARTS – UTILITY/ O.R.
CENTRIFUGE
CHART RACK WITH FOLDERS
CRUTCHES, COMMODES, CANES, WALKERS
DENTAL EQUIPMENT – CHAIR, UNIT, X-RAY
DIATHERMY MACHINE
DRAINAGE PUMP
E.N.T. CHAIR
EXAMINATION TABLE WITH PAD/STIRRUP
EYE EQUIPMENT
FOOD PUMP
GERIATRIC CHAIR
GOOSENECK LAMP
GURNEY – TRANSFER/EMERGENCY CARE
HEMATOCRIT
HOYER PATIENT LIFT
HYPRECATOR
I.V. POLES
INFANT SCALE WITHOUT TABLE
INFANT SCALE WITH TABLE
INSTRUMENT CABINET
LABORATORY OVEN
LABORATORY INCUBATOR
LAUNDRY HAMPER CART
MATTRESSES
MAYO INSTRUMENT TABLE
MINOR SURGERY LIGHT
OFFICE FILE CABINET
OPERATING TABLE
ORTHOPEDIC VACUUM UNIT
ORTHOPEDIC TABLE
OXYGEN CONCENTRATOR
OXYGEN TANK WITH GAUGE
SPECTROPHOTOMETER
STERILIZER
STOOLS
SUCTION PUMP
TISSUE PROCESSOR
TREATMENT CHAIR
TREATMENT TABLE
ULTRA-VIOLET LAMP
WHEELCHAIR

SURGICAL INSTRUMENTS

MINOR SURGERY SET
E.N.T. SET
O.B. GYN SET
ORTHOPEDIC SET
CARDIO-VASCULAR SET
EXAMINATION SET/ CLINICAL

NOTE: ALL ITEMS IDENTIFIED BELOW ARE CONSIDERED **SPECIAL/CALIBRATED EQUIPMENT** AND THEY ARE SUBJECT TO AVAILABILITY.

ANESTHESIA MACHINE
BLOOD ANALYZER
CARDIAC MONITORS
DEFIBRILLATOR
DIALYSIS MACHINE
EKG MACHINE
ELECTRO-SURGICAL UNIT
FETAL MONITOR
INCUBATOR
INFUSION PUMP
LABORATORY REFRIGERATOR
MAMMOGRAM MACHINE
OPERATING ROOM LIGHTS
PHOTO-THERAPY UNIT
STRYKER CIRCLE BED
TREAD MILL
ULTRA-SOUND
VENTILATORS
X-RAY MACHINE 500 MA, 300 MA

MEDICAL SUPPLIES BY CATEGORY

ANESTHESIA/OXYGEN
AMBULATORY BAGS
ADAPTERS
CIRCUITS
ENDOTRACHEAL TUBES
MOUTH PIECES
NEBULIZERS
OXYGEN MASK
OXYGEN TUBING
PULMO-AID TUBING
TONGUE RETRACTORS
TRACHEAL TUBES

FEEDING
FEEDING TUBES – 8Fr to 18Fr
FOOD SUPPLEMENT
LEVIN & CANTOR TUBES
TUBING
GAUGE

I.V. TUBING
ADAPTOR
ADMINISTRATION SETS
ALCOHOL/IODINE SWABS
ANGIO CATHETERS
BLOOD ADMINISTRATION SET
DEXTROSE
EXTENSION SETS
GLOVES
HEPARIN VIALS
I.V. SOLUTION
INFUSION SETS
LUER LOCKS
NEEDLES
PRIMARY SETS
STOP COCK
SYRINGES
VIALS OF SODIUM CHLORIDE

LABORATORY SUPPLIES
BEAKER
GLUCOMETER
HEMOGLOBINOMETER
LANCETS
MICROSCOPE
MICORSCOPE SLIDES
PIPETTE
TUBES
VACUTAINER

ORTHOPEDIC
ACE BANDAGES
ATHLETE TAPE
BACK BRACE
CANE/CRUTCHES TIPS
IMMOBILIZER
NECK BRACE
ORTHOPEDIC PINS
PADDING
PLASTER CAST
SPLINTS
STUMP SOCK
TRACTION BELT

PATIENT CARE
ADHESIVE TAPE
ALCOHOL
BEDPAN
BETADINE SWABS
COTTON
CUPS
DISINFECTANT
EXAMINATION GLOVES
FOOD TRAYS
HAMPER BAGS
HYDROGEN PEROXIDE
K-Y JELLY
KIDNEY BASIN
NEEDLES
PATIEN GOWNS
PITCHERS
SOAP
SYRINGES
URINALS
WASTE CONTAINER

STOMA
ASSORTED SIZES

SURGERY
ADHESIVE TAPE
CAPS
CUTDOWN CATHETERS
DRAPES – assorted
GAUZE
IODINE PREP SOLUTION
MASKS
O.R. TRAYS
PENROSE TUBING
SHOE COVERS
SPECIAL DRESSINGS
SURGICAL GLOVES
SURGICAL GOWN
SURGICAL PACK
SUTURE REMOVAL KIT
SUTURES
YANKEUR SUCTION

URINARY/DRAINAGE
ASEPTO SYRINGES
FOLEY CATHETERS – assorted sizes
IRRIGATION SETS
TUBING
URETERAL CATHETERS

Note: World Medical Relief offers special medicine with a special discount price and long-dated medicines as requested

WORLD MEDICAL RELIEF, INC.

SERVICE FEES FOR INTERNATIONAL SHIPMENTS (APPROVED APPLICATION "A" ONLY)

40 FOOT CONTAINER	$10,500*
20 FOOT CONTAINER	$6,000

Effective July 1, 2024: The handling fee cost will increase to $12,000.
You can receive the reduced rate of $10,500 if you pay in full before July, 1 2024.

SERVICE FEES FOR MISSION/LOCAL SHIPMENTS (APPROVED APPLICATION "B" AND "C" ONLY)

If the Value is:	The charge is:
$ 100 TO $ 14,999	7%
$ 15,000 AND above	4%

The above costs and percentages are subject to revision without notice and do not apply to special medication orders.

ACKNOWLEDGEMENT FORM

This is to acknowledge receipt of a shipment of medicine, medical equipment, medical supplies (include any applicable items) on _____.

The contents of the shipment coincided with the packing lists received and the shipment arrived in good condition.

(Please use the above information as a format to send an acknowledgement ON YOUR LETTERHEAD to World Medical Relief within 30 days of receiving your shipment. We also require receiving photographs of the items in use at your medical facility.)

If the shipment was damaged in any way or if items seem to be missing, please notify WMR immediately.

NOTE: It is imperative that you send your acknowledgement as soon as you receive your donation. Failure to comply may result in suspension of future donations.

Send Letters To:
World Medical Relief, Inc.
Attn: International Program
21725 Melrose Avenue
Southfield, MI 48075

WORLD MEDICAL RELIEF, INC.
RESPONSIBILITY OF FEES AGREEMENT

I, _____**,** a representative of _____

_____with postal address_____

_____,hereby declare responsibility for a shipment to

_____from World Medical Relief, Inc. in
(Name of Hospital/Clinic and Country)

Southfield, Michigan U.S.A. This responsibility extends to all fees involving the shipment (i.e. shipping costs, taxes, custom duties, demurrage fees, etc.).

In the event the recipient institution is unable to get a tax exemption letter, the undersigned and other officials named in our application to World Medical Relief, Inc. shall take the full responsibility whatever the obligation may occur. We are also aware the donation of medical supplies is intended for charitable purposes only and is not for sale or resale. It is intended for the sick, poor and the needy only.

However, World Medical Relief, Inc. has no obligation in any transaction during the process of releasing the container from customs nor shall World Medical Relief, Inc. retrieve any container sent overseas back to the United States.

Signed this _____ day of _____Year_____

_____
Signature

_____
Print Name Title

Witness:

_____