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
1. Name of Recipient ______________________________________________________

   A. Legal address of recipient ____________________________________________

      Street ______________________________________________________________

      City_____________________________ Province ______________________

      State _____________________________ Country ______________________

   B. Type of Institution (Please Specify)

      Hospital _____ Clinic _____ Dispensary ______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) _________________________________

      Facsimile (country code/area code & number) _________________________________

   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) _________________________________

      Facsimile (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. List Of Needs: 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.** Please Attach Additional Sheets With Reference To Questions.

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

   If yes, please use a separate page for each hospital:

   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.

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

******************************************************************************

APPROVED _____ DATE_________________________  DENIED _____ DATE___________________

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

Preamble: World Medical Relief, Inc., 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.
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.**
1. Name Of Sponsoring Institution/Individual_____________________________________

   A. Legal address of sponsoring institution/individual

      Street ____________________________________________________________
      City ______________________ Province ____________________
      State ______________________ Country _____________________
      Telephone (country code/area code & number) _____________________
      Facsimile (country code/area code & number) ______________________
      E-mail address (if available)__________________________

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

      Name ___________________________________________________________
      Street ____________________________________________________________
      City, State, Zip____________________________________________________
      Facsimile (     ) _____________________ 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

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

**SURGICAL INSTRUMENTS**

<table>
<thead>
<tr>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>MINOR SURGERY SET</td>
</tr>
<tr>
<td>E.N.T. SET</td>
</tr>
<tr>
<td>O.B. GYN SET</td>
</tr>
<tr>
<td>ORTHOPEDIC SET</td>
</tr>
<tr>
<td>CARDIO-VASCULAR SET</td>
</tr>
<tr>
<td>EXAMINATION SET/ CLINICAL</td>
</tr>
</tbody>
</table>

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

## LABORATORY SUPPLIES
- Beaker
- Glucometer
- HemoGlobinometer
- Lancets
- Microscope
- Microscope Slides
- Pipette
- Tubes
- Vacutainer

## ORTHOPEDIC
- Ace Bandages
- Athlete Tape
- Back Brace
- Canes/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

## 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
- Yankauer Suction

## URINARY/DRAINAGE
- Asepto Syringes
- Foley Catheters – assorted sizes
- Irrigation Sets
- Tubing
- Ureteral Catheters

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**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

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%

ABOVE RATES ARE EFFECTIVE

January 1, 2022

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 would also appreciate 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 ______________________________________
(Name) (Name of Organization)
___________________________________________with postal address_______________________________

____________________________________________________, hereby declare responsibility for a shipment to
____________________________________________________________from World Medical Relief, Inc. in

(Detroit, 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: