

INSTRUCTIONS:

- Complete all the fields with the information. If the field is not related to your business activity please write Not Applicable (N/A). Note that if you leave it empty, we consider your answer as a NO.
- Attach all the documents required like your Company Code of Conduct, your Company registration, your Company policies and procedures related to compliance and anti-corruption, any other information related to your answer with YES.
- Sign the form electronically and return to your Advita Ortho contact.
- Your timely response is appreciated.
- **PLEASE NOTE THAT NO AGREEMENT CAN BE CONCLUDED UNTIL WE RECEIVE THIS COMPLETED QUESTIONNAIRE AND APPLICABLE SUPPORTING MATERIALS AND HAVE HAD ADEQUATE TIME TO REVIEW AND VERIFY THE STATEMENTS CONTAINED IN YOUR RESPONSE.**

KEY DEFINITIONS:

HEALTHCARE PROFESSIONAL (HCP): means any individual (with a clinical or non-clinical role; whether a government official, or employee or representative of a government agency, or other public or private sector organization; including but not limited to, physicians, nurses, technicians, laboratory scientists, researchers, research coordinators, or procurement professionals) that in the course of their professional activities may directly or indirectly purchase, lease, recommend, administer, use, supply, procure, or determine the purchase or lease of, or who may prescribe medical technologies or related services. Furthermore, any close relative of a healthcare professional is also a public official for the purposes of this questionnaire.

HEALTHCARE ORGANIZATION (HCO): means any legal entity or body (irrespective of its legal or organizational form) that is a healthcare, medical, or scientific association or organization which may have a direct or indirect influence on the prescription, recommendation, purchase, order, supply, utilization, sale, or lease of medical technologies or related services such as a hospital or group purchasing organization, clinic, laboratory, pharmacy, research institution, foundation, university, or other teaching institution, or learned or professional society (except for patient organizations); or through which one or more Healthcare Professionals provide services.

PUBLIC OFFICIAL (PO): Any officer or employee of any government or government-controlled entity anywhere in the world. Public officials also include political parties and party officials, candidates for political office, and employees of public international organizations such as the United Nations. Public Officials also include all levels of employees and officials of any commercial enterprise owned, partially owned, controlled, or operated by a government. Additionally, public officials include any person acting in an official capacity for or on behalf of any government or department, or at any level of federal, state, provincial, county, or municipal government and similar officials of any government in the world. Healthcare professionals, including physicians, are public officials for purposes of this form. Furthermore, any close relative of a public official is also a public official for the purposes of this questionnaire.

CLOSE RELATIVE: Close Relatives include a spouse; the grandparents or the spouse's grandparents, parents, siblings, children, nieces, nephews, aunts, uncles and first cousins; the spouses of any of these people; and any other persons who share the same household with the HCP or Public Official.

COMPANY REGISTRATION FORM: this is the form that provides the registration of the Company in your specific country (copy of the company's commercial registration, articles of incorporation or corporate charter, or business license. For example: K-bis in France, visura in Italy, ABN in Australia, etc.).

1. BASIC INFORMATION

1.1. Legal Name:	
1.2. Address:	
1.3. Company Telephone:	
1.5. Website:	1.4. Country or Countries Where Company Does Business:

2. CONTACT INFORMATION [OF PERSON COMPLETING THIS FORM]

2.1. Name and Title:	
2.2. Telephone Number: Mobile Number:	2.3. Email Address:

3. ORGANIZATIONAL STRUCTURE AND COMPANY OWNERSHIP

3.1. Company's form of organization, or acting as an Individual (Examples: Spa, Srl, Snc, partnership, joint venture, etc.)															
3.2. Related entities. Please list the names, addresses, and contact information of the Company's related or affiliated entities (if applicable):															
a. Company's parent company:															
b. Subsidiary or affiliate companies that may or may not work on behalf of Advita Ortho:															
c. Any other companies or entities in which the Company has a controlling ownership interest:															
d. Does the Company represent or carry products for any other company in the medical device, in vitro diagnostics, pharmaceutical, or biotech industries? If so, please list them.															
<p>3.3. Please list all owners, including individuals and companies, and state the % of ownership of each owner. Please attach an additional sheet if needed.</p> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 20px;"> <thead> <tr> <th style="width: 70%;">Owner's Full Legal Name</th> <th style="width: 30%;">Ownership %</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> </tbody> </table>		Owner's Full Legal Name	Ownership %												
Owner's Full Legal Name	Ownership %														

3.4. In which country the Company has its Bank Account?
3.5. Please provide a copy of your business registration and incorporation documents if you have not done so already.
3.6. If another company owns the Company in whole or in part, please submit business registration and incorporation documents for this Company as well.

4. COMPANY PERSONNEL

4.1. List the names and titles of all officers, directors, or managers of your Company:
4.2. List the names and titles of employees directly or indirectly involved in marketing, distributing, or selling Advita Ortho products:

5. THIRD PARTIES

5.1. Subsidiaries, Distributors, Affiliates, and Business Partners (Third Parties) Please list the names of individuals or companies related to yours, who will be performing as subsidiaries, distributors, affiliates or other business partners for the benefit of Advita Ortho in the following areas:		
a. Promotion of Advita Ortho Products:		
b. Selling or Distributing Advita Ortho Products:		
c. Obtaining or Maintaining Regulatory Approval:		
d. Registration Holder for Advita Ortho Products:		
5.2. Please detail the services and the duties any other entity or person provides with regard to our products.		
5.3. a. Does your company have written contracts with distributors and the other third parties mentioned in 5.1 and 5.2 ? b. Does your company require anti-bribery related terms (e.g., promises not to engage in bribery, termination rights of noncompliance, audit rights) in contracts with such parties or persons?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
	YES <input type="checkbox"/>	NO <input type="checkbox"/>

6. ETHICS AND COMPLIANCE

6.1. Are you familiar with the national laws and regulations in your country, the USA FCPA law, the UK Bribery Act.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6.2. Is your company a member (or adhere to) an industry code (e.g. APACMed, JFMDA, KMDIA, MTAA)? If Yes, which one?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6.3. Does your Company have a code of conduct or anti-corruption policies?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6.4. Does your Company train employees on its code of ethics and anti-corruption policies?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6.5. Advita Ortho provided its code of ethics and the Company policy and procedures outlining ethical business practices expected of its partners. Have you provided them to your employees?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6.6. You received the Third Party Code of Conduct by Advita Ortho. Do you agree to be compliant with its content and provide it to all employees, subsidiaries, distributors, and agents?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6.7. How many times is ethics or compliance training provided in your Company? Please provide a copy of the training that you received or describe the content.	ANNUALLY <input type="checkbox"/> QUARTERLY <input type="checkbox"/> AS NEEDED <input type="checkbox"/> NEVER <input type="checkbox"/> I NEED YOUR TRAINING <input type="checkbox"/>	
6.8. Please select which of the following interactions with HCPS your Company has, and provide the indicative amount:		
a. Promotional and educational materials	YES <input type="checkbox"/>	NO <input type="checkbox"/>
b. Support via educational or research grants	YES <input type="checkbox"/>	NO <input type="checkbox"/>
c. Charitable donations	YES <input type="checkbox"/>	NO <input type="checkbox"/>
d. Meals	YES <input type="checkbox"/>	NO <input type="checkbox"/>
e. Travel	YES <input type="checkbox"/>	NO <input type="checkbox"/>
f. Hotel	YES <input type="checkbox"/>	NO <input type="checkbox"/>
g. Other (please describe)	YES <input type="checkbox"/>	NO <input type="checkbox"/>

7. RELATIONS WITH HCPS AND PUBLIC OFFICIALS

7.1. Are any of the Company's key personnel, or family members of key personnel, or use the services of a current or former:		
a. Public Official or HCP	YES <input type="checkbox"/>	NO <input type="checkbox"/>
b. Close Relative of Public Official or HCP	YES <input type="checkbox"/>	NO <input type="checkbox"/>
c. Political candidate	YES <input type="checkbox"/>	NO <input type="checkbox"/>
d. A person having authority within a government entity to make or influence decisions or recommendations regarding:		
I. reimbursement of Advita Ortho products	YES <input type="checkbox"/>	NO <input type="checkbox"/>
II. bulk purchase of Advita Ortho products for companies, institutions, organizations, etc.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
III. prescribing or dispensing of Advita Ortho products	YES <input type="checkbox"/>	NO <input type="checkbox"/>
IV. approval of registrations, permits or other authorizations related to Advita Ortho products	YES <input type="checkbox"/>	NO <input type="checkbox"/>
7.2. If the answer is Yes to any question above, please provide the full names of any of those individuals:		

7.3. Does your company conduct business with:		
a. Government officials?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
b. Government departments or agencies?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
c. Government Healthcare Organization?	YES <input type="checkbox"/> If YES, please indicate the percentage (%) of the sales that are derived from government contracts.	NO <input type="checkbox"/>

8. PENALTIES AND SANCTION BACKGROUND

8.1. Has your Company, its affiliates or key personnel ever:		
a. Been charged with a criminal offense?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
b. Declared bankruptcy or insolvency?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
c. Been excluded or disbarred for any association (e.g. lawyers, HCPs, etc.)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
d. Been sued for fraud?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
e. Been accused or found guilty of money laundering?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
f. Been subject to any administrative sanction or penalty?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
g. Been accused of or found guilty of bribery or corruption?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

8.2. If the answer to any question is Yes, please provide a short-written explanation, including names of all relevant parties, dates, and description of the crime.

8.3. Has your Company or any of its affiliates' books and records ever been reviewed in any governmental audit or investigation for compliance with anti-corruption laws?	YES <input type="checkbox"/> If YES, please provide documents and information about the review	NO <input type="checkbox"/>
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8.4. Does your Company or its affiliates have any pending or threatened claims, litigation, or investigations that have not yet been resolved or closed?	YES <input type="checkbox"/> If YES, please provide documents and information about the situation	NO <input type="checkbox"/>
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9. CERTIFICATION

AUTHORIZED REPRESENTATIVE OF THE COMPANY		
Full name		
Name of Company		
Title		
E-MAIL		
I hereby certify that:		
I am a duly authorized representative of the Company.	YES <input type="checkbox"/>	INITIALS
	NO <input type="checkbox"/>	
The information I have provided is true and complete to the best of my knowledge.	YES <input type="checkbox"/>	INITIALS
	NO <input type="checkbox"/>	
I understand that Advita Ortho may seek to independently confirm the statements made in this document.	YES <input type="checkbox"/>	INITIALS
	NO <input type="checkbox"/>	
I understand that Advita Ortho will rely on this information in deciding whether to enter into any formal business agreement with the Company.	YES <input type="checkbox"/>	INITIALS
	NO <input type="checkbox"/>	
I am not aware of any additional information or risks related to corruption or bribery to be considered in evaluating this formal business agreement relationship with Advita Ortho.	YES <input type="checkbox"/>	INITIALS
	NO <input type="checkbox"/>	
I consent to Advita Ortho and its affiliates transferring, using and storing the information provided in this form for the purpose of allowing Advita Ortho to conduct research into the legal and business background of the companies and persons identified in the form. I consent also to Advita Ortho transferring, using and storing the information provided in this form to a third party located in the United States or outside of the European Economic Area for the sole purpose of conducting such research on Advita Ortho's behalf.	YES <input type="checkbox"/>	INITIALS
	NO <input type="checkbox"/>	

DATE	STAMP AND SIGNATURE
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