Xeal PHARMA

New Customer Application

PLEASE FILL IN ALL SECTIONS MARKED*

Your Full Business Name:*	**Clinical Sector:** Wholesaler ☐ Pharmacy ☐ Hospital ☐ Practice/Clinic/Surgery ☐ Other ☐
Business Address:*	**Address of Registered Office (if different from business address)***
Postcode:*	**Postcode:***
Contact Name:*	**Email:***
Telephone No.:*	**Fax No.:***
VAT Number:*	**Company Registration No.:***
Name of Regulating Authority*:	
License/Registration No.*:	**Expiry/Renewal Date of License (If appl.):**
Controlled Drug (Home Office) License No (If appl.):	**Controlled Drug (Home Office) License Expiry Date (If appl.):**

Finance Contact Information

Contact Name:*	**Email:***
Telephone No.:*	**Fax No.:***

Trade References

Company Name:*	**Company Name:***
Email Address:*	**Email Address:***
Telephone No.:*	**Telephone No.:***

Terms of payment are 30 days following the end of month statement.

I/We the undersigned have read and understood the terms above and wish to make an application to open an account and in doing so, give permission for a reference to be taken from our bankers and trade references above.

Authorised Signatory:* ____________________ **Date:*** ____________________

Position in Company:* ____________________

FOR OFFICE USE ONLY

Regulatory Authority Registration Check Completed:	**Signed :**	
Customer Account Name:		
Approved by RP/QA Name:	**Signed :**	**Date:**