# New Customer Application

**PLEASE FILL IN ALL SECTIONS MARKED***

| | |
|---|---|
| **Your Full Business Name:*** | **Clinical Sector:**<br>**Wholesaler** ☐ **Pharmacy** ☐<br>**Hospital** ☐ **Practice/Clinic/Surgery** ☐<br>**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:** |