

New Account Request Form

*****Please attach a photographic ID*****

Company Name: Account Ref:

Account Name: (if different to above)

Company Type (please tick one): Sole Trader Limited Liability Partnership Other (pls specify)

Company Registration Number:

VAT Registration Number:

Invoice Address
Telephone:
Fax:
Email:
Web:
Contact name:

Delivery Address
Telephone:
Fax:
Email:
Web:
Contact name:

Credit Terms

Payment is in advance of shipping and may be made by credit card or BACS

Euro	Healthxchange Ireland Limited	BIC	ULSBIE2D
Account number:	12310228	Sort Code	98-50-80
IBAN:	IE67ULSB98508012310228		

I want to pay by credit card, please contact me on

How did you hear about us?

Verbal	Y / N	Magazine	Y / N
Web	Y / N	Exhibition	Y / N
Other

Getting to know you

How many practitioners do you have?	How many treatments do you offer?
How many patients do you see a day on average?	Do you stock skincare? If so, which?
Do you use another pharmacy, if so which?

Prescriber/ Nurse/ Pharmacist Details

Please circle around your appropriate Professional Body:

Name:	Profession: : IMC/ GMC/ DCI/ GDC/ NMBI/ NMC/ M.P.S.I/ GPhC
Address:	Registration no:
Email:

I am fully responsible for all aspects of the medication and will ensure administration in line with HPRA and other regulatory authority guidelines and the Law.

Name:	Signature:	Date:
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I am appointed as agent to take and sign for delivery of medicines on behalf of patients at the Company's addresses; and in my absence I nominate the person(s) below to take and sign for delivery of medicines.

Name (Print):	Signed:
Date:	Email:
Name (Print):	Signed:
Date:	Email:
Name (Print):	Signed:
Date:	Email:

By signing this form I confirm that I am authorised by the Company to enter such agreements; I confirm the above Prescriber/ Nurse/ Pharmacist is an authorised signatory on this account and the account information contained herein is correct. I have read the Privacy Statement and accept your Terms and Conditions available on your website www.calmountpharmacy.com

Signature in acknowledgement and acceptance of the Terms & Condition by:

Name:	Signed:
Position:	Date:

*****Please attach a photographic ID (Passport or Driving License) *****
with this form and email to orders@healthxchange.ie

Tel +353 (1) 4568360 • Fax +353 (1) 4298767 • www.healthxchange.ie

