

New Account Form

CUSTOMER NAME:

TRADING NAME:

COMPANY REG NO:

ADDRESS:

TEL NO:

FAX NO:

EMAIL:

VAT NO:

A/C'S CONTACT:

ESTIMATED MONTHLY PURCHASE:

HOW LONG ESTABLISHED:

TYPE OF BUSINESS (PLEASE TICK APPROPRIATE)

☐ DOCTOR

☐ HOSPITAL PHARMACY

☐ NURSE

☐ GENERAL PRACTITIONER

☐ WHOLESALE

☐ DENTIST

☐ RETAIL PHARMACY

☐ CLINIC

☐ OTHER

BONEFIDES VERIFICATION

*PLEASE ATTACH COPY OF RELEVANT WHOLESALE LICENCE FOR SUPPLY OF MEDICINAL PRODUCTS IF APPLICABLE

NAME OF MEDICAL PRACTITIONER

REGISTRATION NO OF MEDICAL PRACTITIONER

*ALL NEW ACCOUNTS ARE PRO-FORMA INVOICE ONLY UNTIL FURTHER NOTICE. PAYMENT BY CREDIT CARD ONLY

How did you hear about John Bannon Ltd?

☐ Magazine

☐ Referral

☐ Internet

☐ Facebook

☐ LinkedIn

☐ Twitter

☐ Other

* All goods are sold subject to John Bannon Ltd Terms & Conditions

I/ We accept John Bannon Ltd Terms & Conditions.

Signature of Owner/Director/Financial Controller

SIGNED:

POSITION:

DATE:

Please fill in this form and return by email to sarah@johnbannon.ie
or fax to: 0035300353 1661 49 55