Account Application Form – CI Med Products

ABN 58 602 559 026 | Level 25, 100 Mount St, North Sydney NSW 2060 | Phone: 1300 785 202 | sales@cimedproducts.com.au
Processing and approval will take 1-5 business days during which COD applies

Office Use only: Sale Code

Name of Applicant / Business _____ ABN_____

Type of Business _____Year Business established _____

Postal Address: Street _____

Suburb _____ State _____ Postcode _____

Delivery Address: Street _____

Suburb _____ State _____ Postcode _____

Phone: _____ Mobile: _____ Email: _____

Delivery Instructions _____Opening Days & Hours _____

Accounts payable Name: _____ Ph: _____

Accounts payable email address (for CI Med Products to send statement) _____

Director's name: _____

Directors Address: Street _____

Suburb _____ State _____ Postcode _____

Phone: _____ Mobile: _____

Doctor name (Principal Doctor if more than one) _____

Registration details of Doctor: Provider name: _____ Provider No. _____

I (print name) _____ give my permission and take responsibility for restricted pharmaceuticals to be ordered and delivered to the above address.

Signed _____ Email address: _____

Photo ID above Doctor **ATTACH A COPY OF CURRENT DRIVERS LICENSE OR PASSPORT TO APPLICATION**

Monthly Credit applied for: _____

Method of Payment (The most efficient and beneficial method of payment is via credit account).

Credit Card type: Diners ☐ Amex ☐ Mastercard ☐ Visa ☐ or EFT (**CI Med Products: BSB** 032-501 **A/C** 279106)

Credit Card Number _____Expiry Date _____CVV _____

I authorise CI Med Products to debit my credit card at month end on Statement:

(tick) Yes ☐ Name: _____ Position _____Signature_____

Trade Reference (include full name of company and phone number other than mobile)

1. Company Name: _____ Contact Name: _____ Ph: _____
2. Company Name: _____ Contact Name: _____ Ph: _____

Declaration: I, the authorised person from our company, agree to pay all accounts on a strict 30 days from invoice or as agreed and in accordance with our standard terms and conditions. I / we understand that, should payment not be made according to the terms the account facility may be revoked and all amounts owed must be paid immediately to avoid legal action. All CI Med Products Terms and conditions apply as per the website. Freight costs to be agreed upon with customer service after account approval. Expected monthly purchases minimum $500 for credit account approval.

Position _____ Print Name _____

Signed _____ Date _____