



## NEW ACCOUNT REQUEST

Please fill out the form in full in order to receive access to the correct pricing

Date:

Establishment license:  
(Latin America and Canada customers only)

Type of facility

### BILLING INFORMATION

Facility Name:

Address:

City:

State:

Zip:

County:

Country:

Phone Number:

Contact name:

Invoice E-mail Address:

Fax Number:

Federal Tax ID Number:

Tax Exempt (Yes/No):

Preferred Invoice Method:

Preferred Payment Method:

### SHIPPING INFORMATION

Name:

Address:

City:

State:

Zip:

County:

Country:

Phone Number:

Contact name:

E-mail Address:

Fax Number:

Pharmacy License Number:

GLN:

Preferred Order Method:

### PRICING AND CONTRACTS

IDN:

GPO affiliation

GPO Member ID:

Are you a member of a Regional Purchasing  
Coalition or Regional GPO (Yes/No)

If yes, which Coalition or GPO:

Supply chain contact name:

Phone Number:

Email: