



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

select from list

BILLING INFORMATION

Facility Name:

Address:

City:

State:

Zip:

County:

Country:

Phone Number:

Contact name:

Invoice E-mail Address:

Federal Tax ID Number:

Tax Exempt:

Yes

No

If yes, provide a copy
of Tax Exempt Certificate

Preferred Invoice Method:

select from list

Preferred Payment Method:

SHIPPING INFORMATION

Name:

Address:

City:

State:

Zip:

County:

Country:

Phone Number:

Contact name:

E-mail Address:

Pharmacy License Number:

If yes, provide a copy

GLN:

Preferred Order Method:

select from list

PRICING AND CONTRACTS

IDN Affiliation:

Primary GPO Affiliation:

Primary GPO Member ID:

Secondary GPO Affiliation: *(if applicable):*

Secondary GPO Member ID *(if applicable):*

Aggregate Affiliation *(Ex. Regional Purchasing Coalition, Regional GPO)*

Supply chain contact name:

Phone Number:

Email: