ROI

PHARMACY SUPPLIES

NEW ACCOUNT APPLICATION FORM

(PLEASE COMPLETE ALL FIELDS IN FULL, IN BLOCK CAPITALS)

FULL COMPANY NAME: _____

TRADING NAME (IF DIFFERENT): _____

TYPE OF COMPANY: ☐ LIMITED COMPANY ☐ SOLE TRADER ☐ PARTNERSHIP ☐ OTHER

_____ VAT NUMBER IS THIS A GROUP VAT REGISTRATION NUMBER ☐ YES ☐ NO

COMPANY REGISTRATION NO: _____

ADDRESS: _____

_____ POSTCODE: _____

PHONE: _____ FAX: _____

PROPRIETORS/DIRECTOR DETAILS

NAME: _____

ADDRESS: _____

EMAIL: _____ TELEPHONE: _____

☐ **YES, I WISH TO RECEIVE MARKETING INFORMATION VIA THE EMAIL ADDRESS STATED ABOVE**

BUYER/DELIVERY ADDRESS (IF DIFFERENT TO REG. ADDRESS)

NAME: _____ TELEPHONE: _____

JOB TITLE: _____ EMAIL: _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

☐ **YES, I WISH TO RECEIVE MARKETING INFORMATION VIA THE EMAIL ADDRESS STATED ABOVE**

ACCOUNTS CONTACT

NAME: _____ EMAIL: _____

TELEPHONE: _____ FAX: _____

I THE UNDERSIGNED AM A DULY **AUTHORISED SIGNATURE FOR THE BUSINESS** THIS APPLICATION FORM APPLIES TO. I AM PERSONALLY RESPONSIBLE TO UPDATE PHARMACY SUPPLIES LIMITED REGARDING ANY CHANGES TO THE ABOVE COMPANY DETAILS.

NAME: _____

POSITION IN COMPANY: _____

SIGNATURE: _____ DATE: _____

SUMMARY TERMS & CONDITIONS

1. FREE CARRIAGE ON ALL ORDERS OVER €250.00 OTHERWISE A CHARGE OF €5.00 WILL BE APPLIED.
2. WE RESERVE THE RIGHT TO ALTER PRICING WITHOUT NOTICE. E&OE.
3. CLAIMS FOR DAMAGES/ SHORTAGES MUST BE REPORTED WITHIN 24 HOURS OF DELIVERY.
4. PAYMENT 30 DAYS AFTER INVOICE DATE.
5. GOODS REMAIN THE PROPERTY OF PHARMACY SUPPLIES UNTIL PAYMENT IS RECEIVED IN FULL.
6. ROI CUSTOMERS ARE NOT CHARGED VAT BUT ARE REQUIRED TO DECLARE IMPORTS ON VAT RETURN.
7. NEW ACCOUNTS PROFORMA UNTIL CREDIT ESTABLISHED.

ACCEPTANCE TO TRADE IMPLIES FULL AGREEMENT WITH ALL PHARMACY SUPPLIES TERMS AND CONDITIONS WHICH ARE AVAILABLE AT WWW.PHARMACY-SUPPLIES.COM

PHARMACY SUPPLIES LTD, 5-7 TOBERMORE ROAD, DRAPERSTOWN, CO DERRY, BT45 7AG.

TEL: +353 (0) 48 7962 7889 FAX: +353 (0) 48 7962 7111 VAT NO: GB 863 2904 16 EMAIL: SALES@PHARMACY-SUPPLIES.COM WEB: PHARMACY-SUPPLIES.COM

SEPA Direct Debit Mandate

*Unique Mandate Reference

*Creditor Identifier: IE97ZZZ305194

PHARMACY SUPPLIES

Legal Text: By signing this mandate form, you authorise Pharmacy Supplies Limited send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instruction from Pharmacy Supplies Limited.
As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which you account was debited. Your rights are explained in a statement that you can obtain from your bank.
Please complete all the fields below marked *

*Your Name :

Your Address:

Address Line 1_____

Address Line 2_____

*City/postcode

* Country:

* Account number(IBAN)

*Swift BIC

*Creditors Details
Pharmacy Supplies Limited,
The Business Centre, Old Railway Yard,
5-7 Tobermore Road, Draperstown, Co.Derry, BT45 7AG
PLEASE RETURN THE COMPLETED FORM TO THE ABOVE ADDRESS

*Type of payment Recurrent ☑ **or** One-Off Payment ◯ (Please tick √)

*Date of signing:

*Signature(s)