

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

SECTION 1

PHARMACEUTICAL SOCIETY OF NORTHERN IRELAND NO: _____

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: _____

DO YOU OWN ANOTHER SHOP? _____ ACCOUNT CODE: _____

NAME/ADDRESS: _____

SECTION 2

PROPRIETORS/DIRECTOR DETAILS

NAME: _____

ADDRESS: _____

EMAIL: _____ TELEPHONE: _____

I WISH TO RECEIVE MARKETING INFORMATION VIA THE EMAIL ADDRESS STATED ABOVE YES NO

SECTION 3

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

NAME: _____ TELEPHONE: _____

JOB TITLE: _____ EMAIL: _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

I WISH TO RECEIVE MARKETING INFORMATION VIA THE EMAIL ADDRESS STATED ABOVE YES NO

SECTION 4

ACCOUNTS CONTACT

NAME: _____ EMAIL: _____

TELEPHONE: _____ FAX: _____

SECTION 5

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 £150.00 IN NORTHERN IRELAND OTHERWISE A CHARGE OF £2.50 WILL BE APPLIED. | 4. PAYMENT 30 DAYS AFTER INVOICE DATE. |
| 2. WE RESERVE THE RIGHT TO ALTER PRICING WITHOUT NOTICE. E&OE. | 5. GOODS REMAIN THE PROPERTY OF PHARMACY SUPPLIES UNTIL PAYMENT IS RECEIVED IN FULL. |
| 3. CLAIMS FOR DAMAGES/ SHORTAGES MUST BE REPORTED WITHIN 24 HOURS OF DELIVERY. | 6. ALL COST PRICES SUBJECT TO VAT AT 20%. |
| | 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



Instruction to your bank or building society to pay by Direct Debit

Please fill in the whole form using a ball point pen and send it to:

Pharmacy Supplies LTD
The Business Centre,
Old Railway Yard,
5-7 Tobermore Road,
Draperstown,
BT45 7AG

Name(s) of account holder(s)

Bank/building society account number

Branch sort code

Name and full postal address of your bank or building society

To: The Manager Bank/building society

Address

Postcode

Service user number

5 0 6 2 0 8

Reference

P H A R M A C Y S U P P L I E S

Instruction to your bank or building society

Please pay Pharmacy Supplies Direct Debits from the account detailed in this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with Pharmacy Supplies and, if so, details will be passed electronically to my bank/building society.

Signature(s)

Date

Banks and building societies may not accept Direct Debit Instructions for some types of account

DD12

This guarantee should be detached and retained by the payer.

The Direct Debit Guarantee



- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits
- If there are any changes to the amount, date or frequency of your Direct Debit Pharmacy Supplies Ltd will notify you FIVE working days in advance of your account being debited or as otherwise agreed. If you request Pharmacy Supplies Ltd to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit, by Pharmacy Supplies Ltd or your bank or building society you are entitled to a full and immediate refund of the amount paid from your bank or building society
 - If you receive a refund you are not entitled to, you must pay it back when Pharmacy Supplies Ltd asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.