

New Customer Application Form

PLEASE COMPLETE ALL SECTIONS MARKED WITH *

Your Full Business Name:*		Clinical Sector:	
		Wholesaler ☐	Pharmacy ☐
		Hospital ☐	Practice/Clinic/Surgery ☐
		Other (Please Specify)..... ☐	Telehealth Pharmacy ☐
			
Business Address:*		Address of Registered Office: (if different from business address)*	
Postcode:*		Postcode:*	
Contact Name:*		Email:*	
Telephone No.:*		Fax No.:*	
VAT Number:*		Company Registration No.:*	
Regulatory Authorisations & Licences:			
Name of Regulating Authority* (Please Tick where appropriate): MHRA ☐ GMC ☐ CQC ☐ RVC ☐ Others ☐ _____			
License/Registration No.:*		Expiry/Renewal Date of License (If appl.):*	
Controlled Drug (Home Office) License No (If appl.):		Controlled Drug (Home Office) License Expiry Date (If appl.):	
Finance Contact Information:			
Contact Name:*		Email:*	
Telephone No.:*		Fax No.:*	
Trade References:			
Company Name:*		Company Name:*	
Email Address:*		Email Address:*	
Telephone No.:*		Telephone No.:*	
Terms of payment are 30 days following the end of month statement. I/We, the undersigned, have read and understood the terms stated above and wish to make an application to open an account and in doing so hereby authorise Xeal Pharma Ltd to obtain trade and banking references as necessary to assess this application. Authorised Signatory:* _____ Date:* _____ Position in Company:* _____			

FOR XEAL PHARMA USE ONLY		
Regulatory Authority Registration Check Completed: YES/NO	Sign:	Date & Time:
Customer Account Name:	Customer Account Code:	
Approved by QA Name:	Sign:	Date & Time: