CREDIT APPLICATION FORM

Email to aradmin@teammed.com.au

*Compulsory Fields

ACCOUNT NUMBER (office use only)

Legal Business Name*		Trading Name (if different)*
Title*	Principal Doctor | Pharmacist | Practitioner First Name*	Surname*
Medical Centre / Pharmacy / Practice Name		
Type of Business* (GP, Specialist, Dentist, Government, Hospital, Pharmacy, Trade)		ABN*
Entity Type* please tick	☐ Pty Ltd ☐ Ltd ☐ Sole Trader ☐ Partnership ☐ Trustee ☐ Other	
Postal Address*	Street	
	Suburb	State / Pcode
Business Delivery Address* (if different from above)	Building/Shop Unit/Level / Street	
	Suburb	State / Pcode
Special Delivery Instructions* (Include opening days and hours, street level, entrance etc)		

ACCOUNT CONTACTS

Contact Name for Ordering*		E-mail*	
Phone*	Mobile	Fax	Preferred method of communication - please tick* ☐ PHONE ☐ MOBILE ☐ FAX ☐ E-MAIL
Contact Name for Accounts Queries		E-mail*	
Phone*	Mobile	Fax	Preferred method of communication - please tick* ☐ PHONE ☐ MOBILE ☐ FAX ☐ E-MAIL

DIRECTORS/OWNERS DETAILS

Name (Director 1)*	Phone & Mobile*	
Address* (As Appears on Driver's License)		Driver's license No*
E-mail address*		
Name (Director 2)*	Phone & Mobile*	
Address* (As Appears on Driver's License)		Driver's license No*

TRADE REFERENCES (Omitting References might delay your application)

Company Name 1	Phone
Company Name 2	Phone

▶▶ **SCHEDULED PRODUCTS** (S2-S8 Drugs) If you intend to purchase pharmaceuticals, vaccines and local anaesthetics we are required by law to have a copy of your current Medical Board Registration.*

☐ **YES, I intend to purchase scheduled drugs and will supply a copy of my registration with my signature**	**AHPRA Number**		☐ **NO, I will not purchase S2-S8 drugs.**

☐ **DECLARATION: I/WE HAVE READ THE TERMS AND CONDITIONS OF THIS APPLICATION. I/WE AGREE TO ABIDE BY THESE TERMS AND CONDITIONS, IN PARTICULAR THAT ALL ACCOUNTS WILL BE PAID WITHIN THE AGREED PAYMENT PERIOD.** (see www.teammed.com.au for complete terms)

Name(s)	Date
Signature(s)	Position(s)

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