PLEASE RETURN
FOR THE ATTENTION OF:

ACCOUNT APPLICATION FORM

Trading name (Stamp if applicable)	Company Name
	How did you here about us? *(please tick)* Advertisement ☐ Other *(please state)* ☐ Recommendation ☐ _____

Address		Invoice Address *(if different)*	Delivery Address *(if different)*
Postcode			
Tel No:			
Fax No:			
Email			

Please provide a copy of your Wholesalers Dealers License Received? ☐ Yes

How long trading at premises? _____

Contact Name	Mr/Mrs/Ms/Other	First Name	Last Name

Royal Pharmaceutical Society premises Registration No: _____

Limited Company ☐ Yes ☐ No

Company Registered No: *(if Limited Company)* _____
VAT No: *(if Limited Company)* _____
Full Names of Partners/Directors _____
_____

Amount of Credit required? £_____

REFERENCES

BANK	
Branch	
Address	
Sort Code	
Account No:	

	TRADE 1	TRADE 2
Company		
Address		
Postcode		

We accept BCM Specials Terms and Conditions and request the opening of an Account.

Signed _____ Print name _____ Date _____
For and on behalf of the above named Pharmacy

Office Use Only
Registered Number Checked _____
Date Confirmation Letter sent to Pharmacy _____ New Account no _____

Please post or fax your completed form to: BCM Specials, D10 First 114, Nottingham NG90 2PR
Tel: 0115 968 6464 Fax: 0115 959 1098