**Please Fax to: +44 (0) 1923 83 99 83 or email to** [**medicines@jolinda.co.uk**](mailto:medicines@jolinda.co.uk)

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| **PART 1 TO BE COMPLETED BY THE SUPPLIER** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Full Legal Company Name** | | | | | | |
|  | | | | | | |
| **Company Registration Number & Date Company Formed / Start of Trading** | | | | | | |
|  | | | | | | |
| **Trading Name (if different from above)** | | | | | | |
|  | | | | | | |
| **Full Postal Address:** | **Post Code:** | | | | | |
| **Contact Name:** |  | | | **Tel No:** | |  |
| **e-mail:** |  | | | **Fax No:** | |  |
| **Out of Hours Contact:**  **For urgent recalls** | **Name** | | | **Tel No:**  **Mobile no:** | |  |
| **Web Address** |  | | |  | |  |
| **VAT No:** |  | | |  | |  |
| **Opening Hours** |  | | |  | |  |
| **Accounts Department (if different from above)** | | | | | | |
| **Address:** | | **Post Code:** | | | | |
| **Contact Name:** | |  | | **Tel No:** | |  |
| **e-mail:** | |  | | **Fax No:** | |  |
| **Wholesaler**  **Please attach copy of license & GDP Certificate (all pages)** | | **☐** | **Licensed Product Categories**  **Please tick all that apply** | | **Authorised Wholesale Operations**  **Please tick all that apply** | |
| **WDA No or equivalent:**  **Site No:** | | | **☐ POM**  **☐ P**  **☐ GSL**  **☐ Unlicensed Medicines**  **☐ Cold Chain**  **☐ Blood Products**  **☐ Immunological Products**  **☐ With MA in EEA member state**  **☐ Without MA in EEA & intended for EEA market**  **☐ Without MA in EEA & not intended for EEA market** | | **☐ Procurement**  **☐ Supply**  **☐ Holding**  **☐ Export** | |
| **GDP Cert & Expiry date:** | | |
| **Responsible Person:** | | | **Other licenses (e.g. MS ‘Specials”)** | |
| **Technical Agreement Required?** | | | **☐YES**  **☐NO** | | **If YES please complete &**  **return with this form.** | |

|  |  |
| --- | --- |
| **Bank Details** | **NEW ACCOUNTS ONLY** |
| **Account Name** |  |
| **Bank Address** |  |
| **Sort Code** |  |
| **Account Number** |  |
| **IBAN** |  |
| **BIC** |  |
| **SWIFT** |  |
| **Account Currency** |  |

|  |  |
| --- | --- |
| **Trade References (please supply two)** | **NEW ACCOUNTS ONLY** |
| **Company Name** |  |
| **Address** |  |
| **Contact name and Position** |  |
| **Contact Phone / Email Address** |  |
| **Company Name** |  |
| **Address** |  |
| **Contact name and Position** |  |
| **Contact Phone / Email Address** |  |

**A Company Director or Partner or RP must complete the section below**

**Declaration**

**I am authorised to sign and open/verify an account with Jolinda Medical Supplies Ltd and declare that the information provided on this supplier form is complete and accurate.**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **PART 2 FOR OFFICE USE ONLY** |

**FINAL APPROVAL TO BE COMPLETED BY THE JMSL RESPONSIBLE PERSON**

|  |  |  |  |
| --- | --- | --- | --- |
| **Supplier Risk Assessment** | | | |
|  | | | |
| **RESPONSIBLE PERSON APPROVAL** | | | |
| **Approved** | **Name:** | **Signature:** | **Date:** |