**Please Fax to: +44 (0) 1923 839 983 or email to** [**medicines@jolinda.co.uk**](mailto:medicines@jolinda.co.uk)

|  |
| --- |
| **PART 1 TO BE COMPLETED BY THE CUSTOMER** |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Full Legal Registered Company Name** | | | | | | | | |
|  | | | | | | | | |
| **Company Registration Number (Companies House)** | | | | | | | | |
|  | | | | | | | | |
| **Trading Name if Different to Registered Name** | | | | | | | | |
|  | | | | | | | | |
| **Address:** | **Post Code:** | | | | | | | |
| **Contact Name:** |  | | | **Tel No:** | | |  | |
| **e-mail:** |  | | | **Fax No:** | | |  | |
| **Out of Hours Contact Name:**  **For emergency recalls and email** | **Name:**  **email:** | | | **Emergency Mobile Tel No:** | | |  | |
| **Web Address** |  | | | **VAT No:**  **or N/A** | | |  | |
| **Opening Hours for delivery** |  | | |  | | |  | |
| **Accounts Department (if different from above)** | | | | | | | | |
|  | | **Post Code:** | | | | | | |
| **Contact Name:** | |  | | **Tel No:** | | |  | |
| **e-mail:** | |  | | **Fax No:** | | |  | |
| **Delivery Address (if different from above)** | | | | | | | | |
| **Address:** | |  | | | | | | |
| **Post Code:** | | | | | | |
| **Contact Name:** | |  | | **Tel No:** | | |  | |
| **e-mail:** | |  | | **Fax No:** | | |  | |
| **Account Type (tick the relevant box and complete the appropriate registration number below) We can sell to GMC registered Doctors, Dentists, Pharmacies, Independent Prescribers either Pharmacist or Nurse and Wholesalers.** | | | | | | | | |
| **Pharmacy** | | **☐** | **Private Clinic** | | **☐** | **GP NHS** | | **☐** |
| **GPhC Premises Reg. No:** | | | **Lead GP Name(s):**  **GMC Reg. No(s):**  **Please use table** **below to add additional doctors at your practice** | | | **Lead GP Name(s):**  **GMC Reg. No(s):**  **Please use table below to add additional doctors at your practice** | | |
| **Pharmacist Name** | | |
| **IP Pharmacists GPhC Reg. No:** | | |
| **Wholesaler**  **Please attach copy of license & GDP Certificate (all pages)** | | **☐** | **WDA (H) Licensed Product Categories**  **Please tick all that apply below** | |  | **Prescribing Nurse** | | **☐** |
| **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** | | | **Name:**  **NMC Reg. No:** | | |
| **GDP Certificate & expiry date** | | |
| **Responsible Person:** | | |
| **Technical Agreement required?**  **☐YES**  **☐NO**  **If YES please complete & return with this form** | | |

**Additional GP Details for Your Organisation**

|  |  |  |  |
| --- | --- | --- | --- |
| **GP Name** | **GMC Registration No:** | **GP Name** | **GMC Registration No:** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Yellow Fever Centre (if applicable)**

|  |  |
| --- | --- |
| **NaTHNac Registration Nos** | **Verified by (for office use only)** |
|  |  |

**Registered with the CQC add name registered if different to above**

|  |  |
| --- | --- |
|  | **Verified by (for office use only)** |
| **Yes ☐**  **No ☐** |  |

|  |  |
| --- | --- |
| **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** |  |

|  |  |
| --- | --- |
| **Bank Details (New Accounts Only)** | **New Accounts Only** |
| **Account Name** |  |
| **Bank Address** |  |
| **Sort Code** |  |
| **Account Number** |  |
| **IBAN** |  |
| **BIC** |  |
| **SWIFT** |  |
| **Account Currency** |  |

**An authorised employee must complete the section below and it must be signed by one of your prescribers if trading under GMC or NMC.**

**Declaration**

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

**I confirm that I have read and accept the Terms & Conditions. I understand that these may be amended periodically. I also understand that all orders will be placed on those terms (or any terms later adopted by the Company and notified in writing).**

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

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

**Once your account has been approved/verified, we will contact you in writing and orders can then be processed.**

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

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

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