



Application for Credit Account

COMPANY NAME:

PHONE: FAX:

TRADING NAME:

POSTAL ADDRESS:

Name:

Street

Town/City

Postcode

DELIVERY ADDRESS: (If different from above)

Name:

Street

Town/City

Postcode

CONTACT NAME:

EMAIL:

ACCOUNTS PAYABLE CONTACT:

ACCOUNTS PAYABLE EMAIL:

NATURE OF BUSINESS:

DATE BUSINESS COMMENCED:

AVG MONTHLY CREDIT REQUIRED: UNDER \$1000 \$1000-\$9000 OVER \$9000 (Tick one)

BANK/BRANCH

TRADE REFERENCES 3 needed (not utilities, lawyers, accountants or banks)

NAME:

ADDRESS:

PHONE:

NAME:

ADDRESS:

PHONE:



TRADE REFERENCES (cont'd)

NAME:

ADDRESS:

PHONE:

DECLARATION

- Payment: Goods will be invoiced on dispatch and payment is made on 20th month following invoice.
- Ownership: Goods will remain the property of Capes Medical until fully paid for.
- The information supplied is true and correct and that we are/I am authorized to make this application.
- I/We acknowledge having read the credit terms as per this application including terms & conditions, and undertake to abide by them and to settle all accounts due to Capes Medical in accordance with them.
- Under the terms of the privacy act 1993, I/We authorize any person or business or organization to provide the company with such information as they require in response to their credit enquiries. I/We authorize the company to furnish to any third party, details of this application and any subsequent dealings that I/we may have with the company as a result of this application being auctioned by the company.
- Interest on all overdue accounts is payable by the applicant at the rate of 2% per month from the due date for payment until the date of actual payment.
- All costs and expenses (including debt collection charges and commission and/or solicitor's fees) incurred in recovering any overdue amounts will be paid by the applicant as a liquidated sum.

APPLICANTS SIGNATURE:

APPLICANTS NAME:

DATE:

**COMPLETE THIS SECTION ONLY
IF YOU ARE ELIGIBLE TO PURCHASE MEDICINES**

As per our Medsafe obligation we are to comply that new applicants are correctly designated in the Capes Medical ordering system and are authorised to access scheduled medicines (i.e., are scheduled as Prescription, Restricted or Pharmacy Only medicines).

TYPE OF PROVIDER: Medical Practitioner Hospital Reg Nurse (Tick one)

Registration/Licence No:

Capes Medical require copy to be either emailed to accounts@capesmedical.co.nz or faxed to Capes Medical on 07 575 9333

Staff member(s) authorised to purchase scheduled medicines.

OFFICE USE ONLY

NAME:

SIGNED: DATE:

CREDIT HAS BEEN: APPROVED / DECLINED CUSTOMER ACCOUNT #

REMARKS: