Application for Credit Account

Company Name:

Trading Name:

Phone: Fax:

Postal Address:

Name:

Street:

Town/City: Postcode:

Delivery Address (if different from above)

Name:

Street:

Town/City: Postcode:

Contact Name: Email:

Accounts Payable Contact: Email:

Nature of Business:

Date Business Commenced:

Average Monthly Credit Required: Under $1000 $1000-$9000 Over $9000

Bank/Branch:

BIOMEDICAL SERVICES NZ LTD t/a CAPES MEDICAL SUPPLIES | 122 Newton Street, Mount Maunganui, 3116
0800 18 19 19 | support@capesmedical.co.nz | www.capesmedical.co.nz

Trade References 3 needed (not utilities, lawyers, accountants or banks)

Name:

Address:

Phone: Email:

Name:

Address:

Phone: Email:

Name:

Address:

Phone: Email:

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Declaration:

• Payment: Goods will be invoiced on dispatch and payment is to be 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 authorised 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 2020, I/We authorise any person or business or organisation to provide the company with such information as they require in response to their credit enquiries. I/We authorise 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 actioned 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 solicitors fees) incurred in recovering any overdue amounts will be paid by the applicant as a liquidated sum.

Signature of Applicant:

Complete this section only if you are eligible to purchase medicines

In order to meet Medsafe compliance, all new applicants who are authorised to purchase scheduled medicines (Prescription, Restricted or Pharmacy Only Medicines), are required to be appropriately recorded in the Capes Medical ordering system.

Type of provider: ☐ Medical Practitioner ☐ Registered Nurse ☐ Hospital

Registration/License Number:

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

Staff Member(s) authorised to purchase scheduled medicines:

Office Use Only

Name: Signed:

Date: Customer ACC #

Credit: ☐ Approved ☐ Declined

Remarks:

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