Meta Healthcare

FIRSTLINE PHARMA
LOCAL KNOWLEDGE | GLOBAL REACH

ACCOUNT APPLICATION FORM

Company Details	
Name:	
Correspondence Address: **Post Code:**	**Invoice Address:** **Post Code:**
Phone No:	**Fax No:**
Company Registration No:	**VAT Registration No:**
Type of Company	**License Number**
Pharmacy	
Hospital	
Wholesaler	
Other (please specify)	
Bank Details	
Bank Name :	**Account Name :**
Account No:	**Sort Code:**
Address :	
Trade Reference(1)	**Trade Reference(2)**
Address:	**Address:**
Post Code:	**Post Code:**
Phone Number:	**Phone Number:**
I/We agree that all accounts are due and payable in advance.	
Signature:	**Print Name:**

Position:	**Date:**
Please fax back to 01442 240431 or email back to info@metahealthcare.co.uk	
To be Completed By Firstline Pharma	
Payment Terms	**Advance / 30 days from Invoice Date/ Others specify**
Name of Account Manager Firstline Pharmacy.	