ACCOUNT OPENING / AMEND FORM

Please note Photo I.D with signature is needed for all new account holders either driving licence or passport

PERSONAL DETAILS

DR ☐ Dentist ☐ Nurse ☐ H&T ☐ Title: _____ Name: _____

Ltd Company Name: _____ Company Reg No: _____

Invoicing Address: _____

_____ Postcode: _____

GMC/IMC/GDC/IDC/NMC/GPhc/PSNI No: _____ Prescriber: YES ☐ NO ☐

Email Address: _____

Telephone: _____ Mobile: _____

Delivery Address (if different from above): _____

_____ Postcode: _____

PARTNER PRESCRIBER DETAILS

(To be completed by associated Prescriber or Medical Director)

(Photo ID required to process application)

Name: _____

Correspondence Address: _____

_____ Postcode: _____

Home Address (if different from above): _____

_____ Postcode: _____

GMC/IMC/GDC/IDC/NMC/GPhc/PSNI No: _____ Email Address: _____

Telephone: _____ Mobile: _____

Medical Director Declaration: (Please tick to confirm)

☐ I hereby declare I am responsible and indemnified for medicines stocked, stored and used at the premises

Associated Prescriber Declaration: (Please tick to confirm)

☐ I hereby declare I am responsible for seeing all prescription patients face to face for this account and have the appropriate indemnity, and product and procedure knowledge

Please Print and Hand Sign

Signature: _____ Date: _____

Account Conditions and Acknowledgments

Prescriptions	I undertake that private prescriptions will be sent to you by mail the same day for receipt within 72 hours, otherwise I will be re-invoiced including VAT. I understand that the pharmacist has the right to use his/her discretion to decide whether to authorise prescription orders. I agree to provide any further information or clarification as requested, to support this right
Account	I confirm that I am appointed as agent to take delivery and am the authorised signatory on the account. I bear the responsibility for any unauthorised access to my account. I have read the terms and conditions at www.bfmulholland.com/terms-conditions-i7
Products	I am fully responsible for all aspects regarding the prescribed medication at the address on behalf of patients. I confirm that I have the appropriate training and techniques to administer each product. I confirm that I have professional indemnity insurance. I take full responsibility for any products that I prescribe outside of their SPC including dosage and indications
Patients	I confirm that the prescribed item(s) will only be used for the treatment of the named patient on the prescription and that I have undertaken a FACE TO FACE consultation with the named patient. I confirm that I have the consent of the patient to receive the delivery of prescribed products on his/her behalf and that the patient has consented to medfx pharmacy dispensing his/her prescription with the full understanding of his/her choice to use alternative pharmacies.

Account Holder declaration: (Please tick to confirm)

☐ I hereby declare I agree with the Account Conditions and Acknowledgements

Signature: _____ Date: _____

Please Print and Hand Sign

PRIVACY

We believe that based on your purchase you would be interested in other related products and services. We'll contact you about these and look forward to doing business with you again soon. If you don't want to receive marketing from us (including by e-mail or phone) then please let us know by e-mailing medfx@bfmulholland.com. For details of our privacy policy, please visit our website under 'privacy policy'.

PAYMENT INSTRUCTIONS

Please make ROI payments to:

Bank Account Number: 85546407
Sort Code: 90-00-84
Bank: Bank of Ireland
Account Name: BF Mulholland Ltd
IBAN: IE45 BOFI 9000 8485 5464 07
Swift: BOFIIE2D

Please make NI payments to:

Bank Account Number: 73196380
Sort Code: 20-97-65
Bank: Barclays
Account Name: BF Mulholland Ltd
IBAN: GB95 BARC 20976 5731 96380
Swift: BARCGB22

Please return completed form to: medfx@bfmulholland.com or call us on +44 (0) 28 94 452 668 for assistance

Internal Use ONLY

TO BE COMPLETED BY SUPERVISOR	
ORDER ATTACHED	Y / N
CHECK REGISTER	Y / N
PHONE BACK	Y / N
ADDRESS CHECK	Y / N
PHOTO WITH SIGNATURE	Y / N
BANK DETAILS REQUESTED	Y / N
REFER TO SUPERVISOR	Y / N
OKAY TO PROCEED WITH ORDER	Y / N
INFO UPDATED ON CRM	Y / N

SPECIAL REQUIREMENTS:

AUTHORISED BY: .....