# AX Pharmaceutical

## New Customer Application Form

**Please fax 2 pages as below to (416) 352-1618**

1) New Customer Application Form
2) Credit Card Form
3) Copy of State Pharmacy License

## Ship To:

**Company** _____ **Contact** _____

**Address** _____

**City** _____ **State** _____ **Zip** _____

**Telephone**_____ **Fax**_____

**Email**_____

## Bill To (If different than ship to Company)

**Company** _____ **Contact** _____

**Address** _____

**City** _____ **State** _____ **Zip** _____

**Telephone**_____ **Fax**_____

**Email**_____

**Do you have Purchase Orders?** (please circle) **Yes or No**

**Which would you prefer to be invoiced via** (please circle) **Email or Fax**

**Which would you prefer to be billed via** (please circle) **Credit Card or Check**

**Print** _____ **Date**_____

**Authorized Signature** _____

100 West Beaver Creek Rd, Unit 12; Richmond Hill, ON L4B 1H4, Canada
Email: sales@axpharmacetuical.com; Tel: (289)842-3088; Fax: (416) 352-1618

# AX Pharmaceutical

## Credit Card Billing Authorization Form

| | |
|---|---|
| Company Name | |
| Person Authorizing | |
| Amex Number | |
| CVC Number | |
| Expiration Date | |
| Billing Address | |
| City | |
| State | |
| Zip | |
| Telephone Number | |
| Fax Number | |
| Email | |
| I will pay my invoice by Amex or Check | |
| Authorized Representative (print-name) | |
| Authorized Signature Date | |

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