NEW SUPPLIER VERIFICATION FORM
Please Fax to: +44 (0)1923 839983 or e mail to: medicines@jolinda.co.uk

Company Details	
Trading Name	
Company Legal Name (if different to above)	
Address incl postcode.	
Web address (if applicable)	
Type of company e.g. Wholesaler, Private GP, Hospital, Pharmacy	
Company Registration Number (please send copy of certificate)	
VAT Number (please send copy of certificate) if applicable	
Name & WDL/WDA(H) Number & categories (please provide copy if applicable)	
GDP Certificate date issued (please send copy)	
Name & GPHC number (if applicable) & name of registered Pharmacist	
Name & GMC number (if applicable) & name of prescribing doctor	
Name & NaTHNaC registration number (if applicable)	
Contact Details	
Name	
Position	
Phone:	
Email:	
Fax:	
Payment Information	
Invoice address (if different from above)	
Contact Person in accounts	
Phone & Ext/ Mobile	
Email address	
Bank Details	
Account Name	
Bank Address	

Sort Code	
Account Number	
IBAN	
BIC	
Account Currency	
Trade References (2)	
Company Name	
Address	
Contact Name & Position	
Contact Phone / email address	
Company Name	
Address	
Contact Name & Position	
Contact Phone/email address	

A company Director or Partner must complete the section below:

Declaration
I am authorised to sign and open an account with Jolinda Medical Supplies Ltd and declare that the information given on this supplier verification form is complete and accurate.

Signature:

Name:

Position:

Date: