TOTAL
PHARMACY SUPPLY

PLEASE RETURN FORM WHEN COMPLETED:
E mail: info@totalpharmacysupply.com
Fax: (817)861-8307

☐ **New Customer Application** ☐ **Credit Limit Increase**

Date: _____ Customer #_____

Business Name: _____

Mailing Address: _____ Shipping Address: _____

_____ (If additional shipping addresses please fill out second form)

_____ _____

Telephone #: _____ Fax #: _____

Email: _____ Type of Business: _____

How did you hear about Total Pharmacy Supply, Inc ? _____

Type of Business: ( ) Individual ( ) Corporation ( ) Partnership ( ) Other _____

Is your business Tax Exempt (Texas only): ( ) Yes ( ) No Tax Exempt #:_____
(Certificate needs to be provided)

Desired Credit Amount: _____

Names of Partners/Owners/Officers:_____

A/P Contact: _____ Phone: _____ Email: _____

Bank Reference:
Name and Address: _____ Contact Person: _____

_____ Phone #: _____

_____ Fax #:_____

Credit References:

Name _____ Name _____

Address _____ Address _____

_____ _____

Contact Person _____ Contact Person _____

Phone # _____ Phone # _____

Fax #_____ Fax #_____

The signature below authorizes release of credit information to Total Pharmacy Supply, Inc. It also indicates agreement to term of Net 30 unless specifically stated differently.

_____ _____ _____
Signed Title Date

FOR OFFICE USE ONLY:

Order Amount $_____ Approved By _____

Salesperson: _____ Date: _____

Credit Limit: _____ Entered By: _____