Address: 270 Esna Park Dr., Unit 15, Markham, Ontario, L3R 1H3 Phone:1-888-611-5590,905-415-0262 Fax: 905-415-0265

* Not all products applicable – no narcotics or short dated items

REGISTRATION FORM

Please complete and return by fax or mail

APPLICANT INFORMATION

Business Name _____

Address

Street _____ City _____

Province _____Postal Code _____ Country _____

Contact Information

Name _____

Telephone _____ Fax _____

E-mail _____

Web Address _____

Shipping Address (Only if different from Above)

Street _____ City _____

Province _____ Postal Code _____ Country _____

Billing Address (Only if different from Above)

Street _____ City _____

Province _____ Postal Code _____ Country _____

BUSINESS INFORMATION

Type of business (please check circle)

O Independent Pharmacy O Wholesaler O Hospital

O Chain Pharmacy O Clinic

Accreditation Number/DEL _____

Owner(s) _____

Manager(s) _____

Year Established _____

Has this facility previously been an AMB Wholesale Customer? O Ye | O No

List persons who are approved to place orders:

_____

Preferred method of payment: (please check circle)

O COD O Visa O AMEX O MasterCard O Check/ E-Check O Pre- Authorized Debit O On Credit O Invoice

uld you like to take advantage of our preferred return offer? (Please check) O Yes

Approved Account (We will send you a credit application form at your request)

Address: 270 Esna Park Dr., Unit 15, Markham, Ontario, L3R 1H3 Phone:1-888-611-5590,905-415-0262 Fax: 905-415-0265

CREDIT INFORMATION

Name of Business	No. of Employees Type of Business
Full Legal Name (if different)	In Business Since
Address	Business Structure ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Division/Subsidiary
City Province Postal Code	Name of Parent Company
Phone # Fax #	HST #
Contact Name	

Owner's Name	Address

BANK REFERENCE

Name of Bank	Name to Contact
Branch	Address
Account Number	Phone #

TRADE REFERENCES

Firm Name	Contact Name	Phone #	Account #
1.			
2.			
3.			
4.			

ACCURACY OF INFORMATION AND RELEASE OF AUTHORITY TO VERIFY

I hereby certify that the information in this credit application is correct. The information included in this credit application is for use by AMB Wholesale in determining the amount of credit to be extended. I understand that AMB Wholesale may also utilize the other sources of credit information which it consider necessary in making this determination. I hereby authorize the bank and trade references listed in this credit application to release the information necessary to assist ABM Wholesale in establishing a credit limit. Further, I/we agree to abide by the credit sales and returns policies of AMB Wholesale and understand that failure to do so may result in revocation of credit privilege without notice.

Authorized Signature _____ Title _____ Date _____

PRIVATE & CONFIDENTIAL

AUTHORIZATION FOR BANK DEBIT

1. Payer's Name and Address - please print

I/We warrant and represent that the following information is accurate.

Mr. Mrs. Ms. Miss	Surname	First Name
Street		
Town	ZIP	Phone No.

Name of Payer's Financial Institution (the "Processing Institution")		
Street		
Town	ZIP	Account No.

I/We have attached a sample check marked "VOID" to this payer authorization (the "Authorization"). I/We will inform the Payee, in writing, of any change in the information provided in this section of the Authorization prior to the next due date of the PAD (Pre-Authorized Debit).

2. Payee's Name and Address

Name of Payee (the "Payee")	AMB Wholesale	
Street	270 Esna Park Dr. Unit 15	
Town Markham	Postal Code L3R 1H3	Phone No. 416-444-7824

3. I/We acknowledge that the Authorization is provided for the benefit of the Payee and the Processing Institution and is provided in consideration of the Processing Institution agreeing to process debits against my/our account, as listed above, (the "Account") in accordance with the Rules of the Canadian Payments Association.

4. I/We warrant and guarantee that all persons whose signatures are required to authorize withdrawals from the Account have signed the Authorization below.

5. I/We hereby authorize the Payee to issue Pre-Authorized Debits (as defined in Rule H4 of the Rules of the Canadian Payments Association) (the "PAD") drawn on the Account, for the following purpose:

PHARMACEUTICAL PURCHASE

6. I/We may cancel the Authorization at any time upon providing written notice to the Payee.

7. I/We acknowledge that provision and delivery of the Authorization to the Payee constitutes delivery by me/us to the Processing Institution. Any delivery of the Authorization to the Payee, regardless of the method of delivery, constitutes delivery by me/us.

8. The Payee will provide to me/us, at the address provided in Section 1:

(a) with respect to fixed amount PADs, written notice of the amount to be debited (the "Payment Amount") and the date(s) on which the Payment Amount debited will be posted to my/our Account (the "Payment Date"), at least 10 calendar days before the Payment Date of the **first** PAD, and such notice shall be provided every time there is a change in the Payment Amount or the Payment Date(s);

(b) with respect to variable amount PADs, written notice of the Payment Amount and the Payment Date(s), at least 10 calendar days before the Payment Date of **every** PAD; and

(c) with respect to a PAD plan that provides for the issuance of a PAD in response to a direct action of mine/ours (such as, but not limited to, a telephone instruction) requesting the Payee to issue a Pad in full or partial payment of a billing received by me/us for a payment obligation that meets the requirements of Section 2 or Rule H4, no notice is required.

9. The Payee may issue a PAD _____ in a dollar amount up to a maximum of $_____.
(Insert frequency of debits)

(If you will be using the e-check debit only once, enter 1 for the frequency and the $ amount owing. If you are planning on using the e-check debit for future purchases, then leave the space blank.)

10. I/We acknowledge that the Processing Institution is not required to verify that a PAD has been issued in accordance with the particulars of the Authorization including, but not limited to, the amount, or that any purpose of payment for which the PAD was issued has been fulfilled by the Payee as a condition to honouring a PAD issued or caused to be issued by the Payee on the Account.

11. Revocation of the Authorization does not terminate any contract for goods or services that exists between me/us and the Payee. The Authorization applies only to the method of payment and does not otherwise have any bearing on the contract for goods or services exchanged.

12. I/We may dispute a PAD only under the following conditions:
(i) the PAD was not drawn in accordance with the Authorization;
(ii) the Authorization was revoked; or
(iii) pre-notification, as required under Section 8 was not received.

I/We acknowledge that in order to be reimbursed a declaration to the effect that either (i), (ii) or (iii) took place, must be completed and presented to the branch of the Processing Institution holding the Account up to and including 90 calendar days after the date on which the PAD in dispute was posted to the Account.
I/We acknowledge that when disputing any PAD beyond the time allowed in this section, it is a matter to be resolved solely between me/us and the Payee, outside the payments system.

13. I/We agree that the information contained in the Authorization may be disclosed to Royal Bank of Canada as required to complete any PAD transaction.

14. I/We understand and accept the terms of participating in this PAD plan.

15. I/We understand and accept that an additional processing fee of $10.00 Canadian will be added every time the E-check service is used.

_____
(Authorized Signature)

_____
(Client Name in full)

N.B. Include a void check with your paperwork.