Jones
HEALTHCARE GROUP

CUSTOMER MASTER INFORMATION FORM

Invoice To:	**Ship To:** (Leave blank if same as the Invoice contact information)
Legal Name:	Legal Name:
Trade Name (if different):	Trade Name (if different):
Address:	Address:
P.O. Box: City:	P.O. Box: City:
Prov./State: Postal/ZIP code:	Prov./State: Postal/ZIP code:
Country:	Country:
Contact Name:	Contact Name:
Phone: Fax:	Phone: Fax:

Invoice Email (Mandatory):

Communications Email:

☐ Check this box to receive the latest news updates and promotions for our pharmacy products. Please note you can unsubscribe at any time.

Business Information:

Line of business: ☐ Pharmacy ☐ Hospital ☐ Long-Term Care Facility Other:

G.S.T Registration # (Canadian Customers):

IRS # (U.S. Customers):

Date Business Established (current ownership):

Pharmacy Owner:

☐ Check this box if you acquired your ownership from an existing pharmacy

Do you have any other accounts with Jones?

☐ Yes ☐ No If yes, account number or name:

If you belong to a banner or buying group, please select from the list below.

Banner		
Calgary Co-op ☐	Medicine Shoppe ☐	Other: ☐
Canadian Addiction ☐	MediSystem Pharmacy ☐	N/A ☐
CareRX ☐	PharmaChoice ☐	**Buying Group**
Classic Care ☐	Pharmasave ☐	API ☐
Familiprix ☐	Proxim ☐	Care Group ☐
Federated Co-op ☐	Remedy'sRx ☐	HealthPRO ☐
Guardian ☐	Rexall ☐	Mohawk Medbuy ☐
I.D.A. ☐	Rx Healthmed ☐	OnPharm-United ☐
Jean Coutu ☐	Total Health ☐	Rubicon ☐
Loblaws/Shoppers Drug Mart ☐	Whole Health ☐	Other: ☐
Medicine Centre ☐		N/A ☐

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Terms are net 30 days from date of Invoice on approved line of credit **Initial:**

I hereby authorize the company listed above to perform a credit check and verify my credit information **Initial:**

Signature **Date**