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:

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

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**

702 B 2020/01/29