ACCOUNT SET-UP FORM

Facility Information	
Hospital/Surgery Center/Clinic Name:	
License #:	DEA #:
Phone:	Fax Number:
Buyer/Purchaser Contact Information	
Name:	Title:
Phone:	Email:
Accounts Payable Contact Information	
Name:	Title:
Phone:	Email:
Does your facility have a vendor approval process that requires additional requirements in order to place an order?	

Facility Billing Address	**Facility Shipping Address**
Attention: Address: City: State: Zip: Phone:	Attention: Address: City: State: Zip: Phone: Days and Hours of Operations (Package Receiving):