

Account Form

Other than General Practitioners



Please complete ALL fields in BLOCK CAPITALS and return to:

**Williams Medical Supplies, FREEPOST CF3963, Maerdy Industrial Estate,
Rhymney, NP22 5BF**

Signatory Name : _____

Signature: _____

Position : _____

Date: _____

Please note: Only an authorised signatory is acceptable as authorisation of the account

Please Note: a copy of your headed stationary or company stamp

Please
Tick

I have read and understood the terms and conditions of the account and agree to abide by them. _____

I accept that payment is due within 30 days from the end of the month of the invoice date. _____

I would like to order online _____

Trading Name: _____		Delivery Address (if Different from Invoicing address) : _____ _____	
Company Activity _____		Postcode: _____	
Full Invoicing address: _____		Company Registration Number: _____	
_____		Are you registered for VAT: Yes ___ No ___	
_____		VAT Number: _____	
_____		Charity Registraion Number: (if applicable) _____	
Post Code : _____		Opening Times	
Telephone Number : _____		Mon: _____ to _____	
_____		Tues: _____ to _____	
Fax Number : _____		Wed: _____ to _____	
_____		Thurs: _____ to _____	
Will the organisation be placing orders for pharaceuticals?		Fri: _____ to _____	
YES _ NO _	If yes please complete a POM form or enclose a copy of your trading licence	Special Delivery instructions: _____ _____	
Name: _____	Position _____	Email address: _____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

If you wish to make your payments easier through direct debit please call 01685 844739

Tel: 01685 846666 (Mon-Fri 8.30am-6pm) Fax: 01685 844725 email: sales@wms.co.uk Web:

www.wms.co.uk

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