

# POM Form



## Prescription Only Medicines (POM) Medicines Act SI 1921 1980

This form needs to be completed by a registered medical professional and is taken as authorisation for Williams Medical Supplies Ltd. to supply pharmaceuticals to the main account address and such Business / Surgery addresses as are included on this form (Not Residential addresses). The delegating doctor may be resident, visiting or consulting, but authorisation needs to be written.

All POM orders will be verified by Williams Medical Supplies to ensure that the correct details have been supplied.

All controlled drug orders must be hand written and placed using original letter headed stationery signed by a qualified medical practitioner.

**WMS USE ONLY**  
Account Number / Name (Block Capitals Please):.....  
.....

Surgery / Company Name: .....  
Address: .....  
.....  
.....  
..... Postcode:.....

### Delivery Addresses

Delivery Address 1 : .....  
.....  
..... Postcode: .....

Delivery Address 2 : .....  
.....  
..... Postcode: .....

Delivery Address 3 : .....  
.....  
..... Postcode: .....

First Name: ..... GMC/GPC/HPC/GDC Number: .....  
Surname: ..... Date: .....  
Signature: .....

The information provided within this document will be checked against each order placed. It is important that you inform **Williams Medical Supplies** if you, or other nominated persons, intend to leave the practice. **Williams Medical Supplies** will ensure that total confidentiality will be given to information provided within this document.

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



**FREE Delivery on ALL Orders over £100**



**Same-day despatch on orders before 6pm**

### WMS USE ONLY

Status verified by:	Valid Until:	Date Received:
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