Allergy Associates Mgt. Services

NEW ACCOUNT FORM
(for office use only)

Date received: _____

Account No: _____

Type of business: Medical Practice Pharmacy Distributor

Healthcare Institution Other _____

License information (authorizing purchase of prescription products):

☑ Medical Doctor ☐ Pharmacy ☐ Distributor/Wholesaler/Manufacturer

☐ Healthcare Institution

Name of licensee: _____

State of licensure: _____ License number: _____

Staff authorized to order prescription products:

_____

_____

Name of person authorizing prescription product purchases:

_____

Signature _____ Date: _____

Contact info: (phone, fax, email): _____