Alpha Medical Solutions	**Account Application / Amendment Form** **Version 1.0**

This application is made by the Account Holder named below, to establish or amend an account to enable the placement and receipt of scheduled product, irrespective of the commercial obligation.

Customer Type	**Complete Sections**
☐ Pharmacist	1, 6 and 7
☐ Medical / Dental Practitioner	2, 6 and 7
☐ Day Procedure Centre	3, 6 and 7
☐ Hospital (Public or Private)	4, 6 and 7
☐ First Aider (ie: Anaphylaxis)	5, 6 and 7

NOTE: amendments to the primary address, company registration, practitioner or contact details, require amendments to all appliable sections.

SECTION 1 PHARMACY			
Legal entity (in full)			
Trading name (if different)			
ABN		ACN	
Registered Address			
Pharmacist's Name			
Business Phone		Mobile	
Email			
Registration No. or Medicare Agreement		Copy Attached	☐ Yes ☐ No (specify reason below)
Pharmacist's AHPRA Number		Copy Attached	☐ Yes ☐ No (specify reason below)
Comments			

SECTION 2 MEDICAL / DENTAL PRACTITIONER			
Practitioner Name			
Practice Address			
Business Phone		Mobile	
Email			
AHPRA Number		Copy Attached	☐ Yes ☐ No (specify reason below)
Any Conditions or Restrictions	☐ Yes ☐ No (specify)		
Certificate of Registration		Copy Attached	☐ Yes ☐ No (specify reason below)
Comments			

SECTION 3 DAY PROCEDURE CENTRE			
Drug Licence held by the facility	☐ Yes – complete Section 3 ☐ No – complete Section 2 in the name of the primary Practitioner		
Name of Authorised Person			
Position			
Name of Centre (in full)			
ABN		ACN	
Delivery Address			
Business Phone		Mobile	
Email		Website	
Comments			

SECTION 4 HOSPITAL (PUBLIC or PRIVATE)			
Hospital Name (in full)			
ABN		ACN	
Registered Address			
Contact name			
Business Phone		Mobile	
Email		Website	
Drug Licence Number		Copy Attached	☐ Yes ☐ No (specify reason below)
Comments			

SECTION 5 FIRST AIDER (ie: ANAPHYLAXIS)			
First Aider's Name			
Place of Practice			
Business Phone		Mobile	
Email			
Medications requested (ie: EpiPen)		List Attached	☐ Yes ☐ No
First Aid Certificate *		Copy Attached	☐ Yes ☐ No (specify reason below)
First Aid Training *		Copy Attached	☐ Yes ☐ No (specify reason below)
Letter of Employment		Copy Attached	☐ Yes ☐ No (specify reason below)
Comments			

**Issued / approved by WorkCover Authority or other organisation approved by the Health Authority. Medicines requested must be in scope of the First Aid Certification, Training and NSW Poisons and Therapeutic Goods Regulation Appendix C requirements.*

SECTION 6 SUPPLY AGREEMENT		
Account Type	☐ Pre-Paid	☐ 30-Day Account (Financial Statements and Trade References Required)

FINANCIAL STATEMENTS	
Financial Statements	☐ Most recent Balance Sheet and P&L attached to this form.

TRADE REFERENCES (Major Suppliers only).

1. Name		Phone		Email	
2. Name		Phone		Email	
3. Name		Phone		Email	

SECTION 7 DECLARATION OF AUTHORISED PERSON(S)

Product cannot be supplied until this form is completed, signed and returned with all applicable supporting documentation.
A full scanned copy of the registration, licenses and/or authorities issued by the TGA, NSWMoH or equivalent health authority is required to enable account setup and verification in accordance with legislation.
Please note that an AHPRA or equivalent screenshot is not appropriate evidence of registration.

By signing below, I the Authorised Person named in the account application form, understand that:

1. I am responsible for the order, supply and administration (as applicable) of the product,
2. I will not permit any other person to order, receive or use the product received,
3. I will not on-supply product outside of my legislated authority,
4. I must provide proof of registration as and when requested by Alpha Medical Solutions,
5. All deliveries will be addressed to myself, the Authorised Person,
6. Distribution of scheduled product will never be to a residential address, only the licensed / authorised premises,
7. All invoices will be marked to my attention,
8. I will notify Alpha Medical Solutions of any changes related to this account,
9. The information provided within this application is true and accurate,
10. I have provided financial statements and trade references (where applicable), and
11. I understand my legal obligations associated with the order and receipt of scheduled goods.

Name (please print)	Position	Signature	Date

Please return the completed form and supporting documents via email to info@alphamedicalsolutions.com.au or in hard copy format to Alpha Medical Solutions Pty Ltd PO Box 745, St Ives NSW 2075.

OFFICE USE ONLY			
Date Received		Account Number	
Any medication restrictions?	☐ No ☐ Yes (specify)		
Notes			
Checked by	Print Name:	Initials:	Date: