ACCOUNT FORM

ROCKS MOSMAN PHARMACY
SHOP 11/50 HARVEY STREET
MOSMAN PARK WA 6012
PHONE: 08 9384 5165
FAX: 9384 3293

CUSTOMER ACCOUNTS

Thank you for enquiring about our account system. We are happy to provide you with an account providing the following conditions are adhered to by all concerned.

1. All accounts are to be finalized within 30 days of the statement date. Statements will be sent as soon as practicable after the end of the month. Accounts not paid will be suspended until payment is received.

2. Parental permission is required if the account is to be used by any person under the age of 18. Parents may specify any limitations in product, service or monetary value as required. Such limitations are to be in writing.

3. Full name, address and identification to be provided.

Name: _____

Address: _____

_____ Post Code: _____

Address where statement is to be sent: _____

_____ Post Code: _____

If under 18
I, _____ of _____

_____

Give my permission for _____ to use this account.

Limitations
This account is limited to $_____ value per month.

This account may only be used to purchase medications. Other limitations (specify)

_____

_____

_____

Anticipated or intended monthly purchases: _____

Signed: _____