**Please Fax to: +44 (0) 1923 83 99 83 or email to** **medicines@jolinda.co.uk**

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| **PART 1 TO BE COMPLETED BY THE SUPPLIER** |

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| **Full Legal Company Name**  |
|  |
| **Company Registration Number & Date Company Formed / Start of Trading** |
|  |
| **Trading Name (if different from above)** |
|  |
| **Full Postal Address:** | **Post Code:** |
| **Contact Name:** |  | **Tel No:** |  |
| **e-mail:** |  | **Fax No:** |  |
| **Out of Hours Contact:****For urgent recalls**  | **Name** | **Tel No:****Mobile no:** |  |
| **Web Address** |  |  |  |
| **VAT No:** |  |  |  |
| **Opening Hours**  |  |  |  |
| **Accounts Department (if different from above)**  |
| **Address:** | **Post Code:** |
| **Contact Name:** |  | **Tel No:** |  |
| **e-mail:** |  | **Fax No:** |  |
| **Wholesaler****Please attach copy of license & GDP Certificate (all pages)**  | **☐** | **Licensed Product Categories****Please tick all that apply**  | **Authorised Wholesale Operations** **Please tick all that apply** |
| **WDA No or equivalent:****Site No:** | **☐ POM****☐ P****☐ GSL****☐ Unlicensed Medicines****☐ Cold Chain****☐ Blood Products****☐ Immunological Products****☐ With MA in EEA member state****☐ Without MA in EEA & intended for EEA market****☐ Without MA in EEA & not intended for EEA market** | **☐ Procurement****☐ Supply****☐ Holding****☐ Export** |
| **GDP Cert & Expiry date:**  |
| **Responsible Person:** | **Other licenses (e.g. MS ‘Specials”)** |
| **Technical Agreement Required?** | **☐YES****☐NO**  | **If YES please complete &** **return with this form.**  |

|  |  |
| --- | --- |
| **Bank Details**  | **NEW ACCOUNTS ONLY** |
| **Account Name** |  |
| **Bank Address** |  |
| **Sort Code** |  |
| **Account Number** |  |
| **IBAN** |  |
| **BIC** |  |
| **SWIFT** |  |
| **Account Currency** |  |

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| --- | --- |
| **Trade References (please supply two)** | **NEW ACCOUNTS ONLY** |
| **Company Name** |  |
| **Address** |  |
| **Contact name and Position** |  |
| **Contact Phone / Email Address** |  |
| **Company Name** |  |
| **Address** |  |
| **Contact name and Position** |  |
| **Contact Phone / Email Address** |  |

**A Company Director or Partner or RP must complete the section below**

**Declaration**

**I am authorised to sign and open/verify an account with Jolinda Medical Supplies Ltd and declare that the information provided on this supplier form is complete and accurate.**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **PART 2 FOR OFFICE USE ONLY** |

**FINAL APPROVAL TO BE COMPLETED BY THE JMSL RESPONSIBLE PERSON**

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| **Supplier Risk Assessment** |
|  |
| **RESPONSIBLE PERSON APPROVAL** |
| **Approved**  | **Name:** | **Signature:** | **Date:** |