MAKSPHARMA AND DIAGNOSTICS INC

Tel : 516-323-1255 | Fax: 866-266-1217
Admin@MaksPharma.com | www.MaksPharma.com
2365 Milburn Ave, Bldg. #2, Baldwin, NY 11510-1711

CREDIT APPLICATION

BUSINESS CONTACT INFORMATION

TYPE OF BUSINESS: ☐ RETAIL PHARMACY ☐ ONLY WHOLESALER ☐ OTHER (PLEASE SPECIFY) _____

Company Name		Date business commenced: _____	
D/B/A OR Formerly Know As Names		CORPORATE STRUCTURE ☐ Sole proprietorship ☐ Partnership ☐ Corporation ☐ Other	
Phone | Fax			
E-mail			
DUNS Number			
Tax ID Number		**Contact Person**	
Registered company address City, State, Zip		Name	
Shipping Address City, State, Zip		Phone Fax	
Billing Address City, State, Zip	☐ Check here if Billing Address is as same as Shipping Address	Email	
		Job Title	

BUSINESS/TRADE REFERENCES

Company name		Phone	
Address		Fax	
City, State ZIP Code		E-mail	
Type of account		Other	
Company name		Phone	
Address		Fax	
City, State ZIP Code		E-mail	
Type of account		Other	

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Company name		Phone	
Address		Fax	
City, State ZIP Code		E-mail	
Type of account		Other	

BANK REFERENCE

Bank Name		Phone & Contact Name	
Address		Fax	
City, State ZIP Code		E-mail	
Type of Account	☐Savings ☐ Checking ☐ Other	Account Number	

OWNER(S) INFORMATION

(Use Additional Sheets if Needed)

Name	Title	Pharmacist (Yes/No)	License No. & State (If Applicable)	Work Location (Address)

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SUPERVISING PHARMACIST INFORMATION

(Use Additional Sheets if Needed)

Name	License No.

BUSINESS INFORMATION

Do you own any other Pharmacy and/or Pharmaceutical Wholesale Business? (YES / NO)
If yes, please indicate below (use additional sheets if needed):

Name of Company	Address	License No.	Has your License ever been suspended/revoked?
			YES/NO
			YES/NO

1. Have you ever been enjoined, disciplined, fined, punished, or the like for violating any federal or state laws regulating prescription drugs or devices? (YES / NO)
2. Have you ever been found guilty, pled guilty, or pled nolo contendere to any criminal offense? (YES / NO)
3. Can you comply with all applicable statutes and regulations governing wholesale distribution where licensed or registered and comply with the more stringent law or regulation as determined by conflicts of law rules? (YES / NO)
4. Have you ever engaged in the unlawful distribution of prescription drugs? (YES / NO)

EXPORT RESTRICTIONS

The merchandise purchased from MAKS PHARMA AND DIAGNOSTICS INC cannot be exported for the purposes of RLD, relief work, individual patients, and/or distributing without authorization of MAKS PHARMA AND DIAGNOSTICS INC.

AGREEMENT

1. All invoices are to be paid by ACH agreement 21 days from the date of the invoice or on the same day to your credit card based on the option selected
2. Claims arising from invoices must be made within seven working days.

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3. By submitting this application, you authorize **MAKS PHARMA AND DIAGNOSTICS INC** to make inquiries into the banking and business/trade references that you have supplied.
4. All vendor and customer licenses will be verified annually using data from appropriate state and federal agencies to verify identity, legitimacy, and proper operation of entities seeking to sell or purchase prescription drug and device products, including the verification that trading partners are authorized pursuant to federal law.
5. By signing below, you agree with **MAKS PHARMA AND DIAGNOSTICS INC's** *Export Restrictions* listed in the application above and answered all questions pertaining to licensure and businesses truthfully and all other information provided is true.
6. Please sign below and submit with a copy of State License and DEA.

SIGNATURES OF OWNER(S)
(Use Additional Sheets if Needed)

Signature		Signature	
Name and Title		Name and Title	
Date		Date	

CONSENT TO FAX/EMAIL:

The information provided in this application will not be sold or shared with anyone. All information obtained will remain ONLY with Maks Pharma and Diagnostics Inc. Maks Pharma and Diagnostcs Inc. is committed to staying current with our customers' needs. We are aware that most of our customers would prefer to do all business through an E-Mail system or via fax or both.

With that in mind, we ask that you take a moment to complete the following and give us the most current e-mail address and fax number(s) needed when communicating with you.

Fax Number: _____ Secondary Fax Number: (if any):_____

Designated E-mail Address: _____
(To be used to electronically deliver policies, applications, and/or other contract related correspondence such as cancellations, approvals, etc. to your office.)

By signing below, I am authorizing and hereby consent to receive faxes and emails sent by or on behalf of Maks Pharma and Diagnostics Inc.

_____ _____ _____
Signature of authorized company representative ***Title*** ***Date***

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ACH DEBITS AND/OR CREDITS AUTHORIZATION AGREEMENT

Account # _____ _

_____, (Applicant's legal name / DBA name) hereby authorizes MAKS PHARMA AND DIAGNOSTICS, INC. henceforth referred to as (Company), to initiate debit entries to my account for invoices due to the company. If necessary the company may initiate credit entries and adjustments for any debit entries in error. Credit entries may only be initiated to the same depository and account from which it was debited from originally. This authorization is to remain in full force and effect until company and depository have received written notification from (Corporate Name) of its termination in 30 days and in such a manner as to afford Company and Depository a reasonable opportunity to act on it.

_____x **Standard ACH Account Terms: Net 21 from date of invoice,**

I am a new ACH participant and currently do not have an ACH account authorized with MAKS PHARMA AND DIAGNOSTICS, INC. Please utilize below information for ACH invoices (debits/credits).

Bank Name: _____

Branch: _____

City: _____

State: _____ ZIP:_____

Transit/ABA#:_____

Account #: _____

(Required) Voided Check or Bank Document Attached: _____

Signature of Applicant's Owner or Officer	(Date)
Applicant's Co-Owner Signature (if applicable)	(Date)

By signing this agreement, you are authorizing this contract until the time of termination. A photocopy or a fax copy of this agreement may be furnished in place of the original.

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CREDIT CARD AUTHORIZATION

PAY AS YOU GO (Invoices will be charged on your credit card AS SOON AS AN ORDER IS SHIPPED)

I am a new PAY AS YOU GO participant and currently do not have a CREDIT CARD account authorized with MAKS PHARMA AND DIAGNOSTICS, INC. Please utilize the below information for all invoices (debits/credits).

CREDIT CARD TYPE (PLEASE CHECK ONE)				I, _____ AUTHORIZE MAKS PHARMA AND DIAGNOSTICS, INC. TO MAKE: **( ) RECURRING ( ) SINGLE** CHARGES TO MY CREDIT CARD LISTED FOR ALL PURCHASES. AS THE CREDIT CARD HOLDER, I HEREBY AUTHORIZE THE RECEIPT OF ALL MERCHANDISE AT THE SHIPPING ADDRESS LISTED ABOVE. YOU MAY CANCEL THIS AUTOMATIC BILLING ANY TIME BY WRITING TO US AT THE ABOVE ADDRESS.
( ) VISA	**( ) MASTER CARD**	**( ) DISCOVER**	**( ) AMEX**	
NAME AS IT APPEARS ON CARD				
CREDIT CARD NUMBER				
SECURITY CODE (CVC)		**EXPIRATION (MM/YY)**		
*FOR MASTER CARD, VISA AND DISCOVER THIS IS THE LAST THREE DIGITS ON THE NUMBER ON THE BACK OF THE CARD. FOR AMERICAN EXPRESS IT IS THE FOUR DIGITS IN THE FRONT OF THE CARD.				
BILLING ADDRESS				AUTHORIZED CARDHOLDER SIGNATURE
STREET		**CITY**		
STATE	**ZIP**	**COUNTRY**		DATE
MAKS PHARMA CUSTOMER ACCOUNT #				

PLEASE FAX US THIS FORM WITH **ENLARGED** AND **LIGHTENED** COPIES OF FRONT AND BACK OF THE CREDIT CARD AND CARDHOLDER'S DRIVER'S LICENSE. THIS IS REQUIRED TO PROVE THAT YOU ARE THE ACTUAL CARDHOLDER AND HAVE THE CARD IN YOU POSSESSION, AS WELL AS MATCH THE SIGNATURE ON THIS FORM TO IT.

YOUR COMPLETION OF THIS AUTHORIZATION FORM HELPS US TO PROTECT YOU, OUR VALUED CUSTOMERS, FROM CREDIT CARD FRAUD. ALL INFORMATION ENTERED ON THIS FORM WILL BE KEPT STRICTLY CONFIDENTIAL BY OUR COMPANY.

Note: Do not complete this if you have signed for ACH terms.

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Pharmacy Information:

Authorized Purchaser(s) Name / Title:

Hours of Operation

MON	TUE	WED	THU	FRI	SAT	SUN

(OPTIONAL INFORMATION)

Wholesalers Info (Please Circle all applicable)

Amerisource Bergen/ Bellco HD Smith McKesson Cardinal Health Kinray Rochester Drugs Corp (RDC)

Anda Parmed Harvard Masters Rivercity Top Rx IPC

Please Name any other generic wholesalers you are currently doing business with…….

……

Do you buy online through any of the following?

Trxade Pharmsaver EzriRX Other:_____