



Account Opening Form

Date of application: _____ Are you operating as a new clinic? Yes No If no, in business since: _____
 YYYY / MM / DD OR YYYY / MM / DD
 If yes, indicate the clinic's opening date: _____
 YYYY / MM / DD If no, previous #: _____

***Business Address**

Legal business name _____

Trade name** _____

Name of the owner or the principal veterinarian _____

Business address _____

City _____

Province _____ Postal code _____

Phone No. _____ Fax No. _____

E-mail _____ Web site _____

Personal Address (Ibid: Yes No)

Name _____

Address _____

City _____

Province _____ Postal code _____

Phone No. _____ Fax No. _____

E-mail/Web site _____

Registered with Association For internal use only

Signature _____

****IMPORTANT** : The trade name and the shipping addresses must be registered at your professional association.
 If you have other shipping addresses, please annex them to this document.

<p>Language of correspondence</p> <p><input type="checkbox"/> French <input type="checkbox"/> English</p>	<p>Billing and correspondence</p> <p><input type="checkbox"/> To the business address <input type="checkbox"/> To the personal address</p>	<p>**Delivery</p> <p><input type="checkbox"/> To the business address <input type="checkbox"/> To the personal address</p>
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Contact

Name of person in charge of purchasing _____

Name of person in charge of accounting _____

To whom should we direct our promotional publications _____

***Estimated annual purchases through CDMV**

Will CDMV be your main distributor ? _____

***Type of business**

Sole Proprietorship
 Owner's Name: _____

Professional Business
 Owner's Name: _____

Company
 Names of shareholders: _____

***Account Holder's Profession**

Veterinarian - Licence No.: _____

ASAQ Member
 ASAQ membership effective date (year / month / day): _____

Pharmacist - Licence No.: _____

Head of which type of organization or service?

Municipal
 Provincial
 Federal
 Teaching or research
 Others (specify): _____

Other profession (specify): _____

Discipline

Small animals Large animals
 General practice Teaching and research
 Others (specify): _____

Terms of payment required

Cheque
 Credit card: Visa Mastercard
 ADP** - 2 statements (due date on the 15 and the last day of the month)

** ADP = automated debit payment. You will be asked to duly complete a registration form.
 † : Certain conditions apply.

I wish to take advantage of (please check only 1 option):

All delayed billing and extended payment promotions on veterinary products
 Delayed billing and extended payment promotions on parasiticide/heartworm products only
 No delayed billing or extended payment promotions on veterinary products



Account Opening Form (continued)

Names of professionals practicing in your business

* For government organizations, indicate the name of the veterinarian or pharmacist in charge

Name (capital letters)	Licence No.	Partner	Employee	Government Org.*
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(If you are more than three professionals, please provide all necessary information on an additional sheet.)

Bank Information

Name of your bank or financial institution _____ Account Number _____

Address _____

City _____ Province _____ Postal code _____

Phone No. _____ Fax No. _____

Name of manager or contact _____

Credit References (Names of three major suppliers. Not required for government organizations.)

Name _____ Phone No. _____

Name _____ Phone No. _____

Name _____ Phone No. _____

Do you have a provincial tax licence no. ? Yes* No

***If so, you must attach a copy of your tax exemption form duly completed and signed.**

Please notify us in writing of any change to your account (names, addresses, bank information, etc.)

Declaration (mandatory)

We promise to pay all invoices according to the terms specified herein. Failing this, we agree to defray all interest fees (1.5% per month - 18% per year) on any outstanding balances. We acknowledge that the merchandise purchased through CDMV Inc. remains the exclusive property of the latter until the invoices are paid in full. We certify that the above-mentioned information is accurate and that we are duly authorized to endorse this document. Moreover, we expressly authorise CDMV inc. to obtain all the necessary information concerning our credit from financial institutions, suppliers or any other part connected to the present request for the opening of our account, as well as anytime thereafter.

Name (capital letters)

Signature of an authorised applicant (Both parties acknowledge the validity of a faxed signature as an original one.)

Title

Date

Please **fax back the filled form** to 1-800-363-3134 **or by email** at: account.info@CDMV.com

IMPORTANT : Please count a minimum of 5 working days for your file study.