



CDMV account opening and update form

Application date: (YYYY-MM-DD) _____

New account Update

Is it for a new practice? Yes No

If yes, opening date: (YYYY-MM-DD) _____

If no, in business since: (YYYY-MM-DD) _____

Or, account No.: _____

Section 1: Addresses

Shipping address

Legal business name _____

Trade name (name of clinic)* _____

Name of the veterinarian in charge _____

Business address _____

City _____ Province _____ Postal code _____

Phone _____ Web site _____

Email _____

Billing address (same as shipping address)

Last name _____

First name _____

Address _____

City _____

Province _____ Postal code _____

Phone _____

Email _____

Preferred language of communication: French English

***IMPORTANT: The trade name (name of clinic) and the shipping addresses must be registered with your regulatory body. If you have any other shipping addresses, please attach them to this document.**

I confirm that both the trade name (name of clinic) and the shipping addresses are registered with my regulatory body.

Section 2: Key contacts

Name of person in charge of purchasing _____ Phone _____ Email _____

Name of person in charge of accounting _____ Phone _____ Email _____

Will CDMV be your main distributor? Yes No

Estimated annual purchases: _____

Section 3: Type of business

Sole proprietorship Owner's name: _____

Professional business Owner's name: _____

Company Names of shareholders: _____

Account type: Veterinary establishment Mobile veterinary service Personal veterinary account Research and teaching institution

Shelter Government agency Laboratory Others: _____

Discipline: Small animals Mixed practice Large animals Equine Others: _____

Section 4: Account holder's profession

Veterinarian ASAQ Member Pharmacist Other profession

Licence No.: _____ Effective date of membership: _____ Licence No.: _____ Specify: _____

Section 5: Methods of payment

Preferred payment option

EFT (Electronic funds transfer). Please make sure to add CDMV as a payee with your financial institution.

Credit card transactions (for online orders only): Visa Mastercard

ADP (Automatic debit payments): Two statements (payments due on the 15th and the last day of the month).
A registration form will be sent to you. Certain conditions apply.

Section 6 : Deferred billing

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

- All deferred billing offered by suppliers.
- Deferred billing on parasiticide products only.
- No deferred billing.

Section 7: Names of professionals practicing in your business

Please give the names of the professionals responsible for purchasing medications and controlled substances.

Name (block letters) Licence No.

Name (block letters) Licence No.

Name (block letters) Licence No.

If there are more than three professionals, please provide, on a separate sheet, the information for each additional person and attach a copy to this document.

New clients

Section 8: Financial institution

Name of your financial institution Account No.

Address City

Province Postal code Phone

Name of manager or key contact Email

Section 9: Credit references

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

Name Phone

Name Phone

Name Phone

Do you have a tax exemption number? Yes No

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

IMPORTANT: Please notify us in writing of any changes to your account (names, addresses, financial institution, etc.)

Section 10: Declaration

We commit to pay all invoices according to the terms specified therein. Should we fail to do so, we agree to pay administration fees of 1,5% per month (18% per year) on any outstanding balances. We acknowledge that the merchandise purchased through CDMV Inc. remains the sole property of the latter until all invoices are paid in full. We certify that the above information is accurate and that we are duly authorized to sign this document. Moreover, we expressly authorize CDMV Inc. to obtain all the necessary information about our credit from financial institutions, suppliers or any other party related to this application for opening our account, as well as anytime thereafter.

Signature of the Professional responsible for the account. (Both parties acknowledge the validity of a digital signature as an original one.) Date (YYYY-MM-DD)

Name (block letters) Title of signatory

Once completed and signed, please return this form to: account.info@CDMV.com or fax it to 1-800-363-3134. A confirmation receipt will be sent to you by email once your account is open or has been updated.