PROFESSIONAL
NEW ACCOUNT APPLICATION

PRACTITIONER BRANDS

AllVia™ | CompliMed® MEDICAL RESEARCH GROUP | Oakmont Labs® THE PROFESSIONAL'S CHOICE™

PRACTITIONER INFORMATION

Practitioner Name:_____ Professional Title:_____
(i.e. MD, ND, DC, LAc, DO, RN, PhD, etc)

Name of Clinic/Buyer:_____

IMPORTANT: In order to process your application, please complete and submit this form along with a copy of your **State Practitioner's License** or **Professional Certificate** to: (Email) customerservice@elephantpharm.com or (Fax) 800-272-0948

Should you need assistance or have any questions, please contact our Customer Service Department at 800-272-1754

REFERRAL INFORMATION

How did you learn about these professional brands?

☐ Tradeshow/Seminar:_____ _____ _____
(Event) (Location) (Date)

☐ Professional School ☐ Professional Colleague ☐ Sales Representative

☐ Publication:_____ ☐ Website:_____

ACCOUNT INFORMATION

Shipping Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Website:_____ Office Hours:_____

Billing Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Primary Contact Person:_____

PAYMENT OPTIONS

We accept payment by credit card

DISCOVER NOVUS | MasterCard | VISA | AMERICAN EXPRESS Cards

UNIFORM SALES & USE TAX CERTIFICATE

I certify that the buyer listed above is engaged as a (check all that apply): ( ) Retailer ( ) Wholesaler ( ) Other (specfy): _____

and is registered with the below listed state(s) within which seller would deliver purchases to buyer and that any such purchases are for wholesale or resale, to be resold in the normal course of business and that buyer is in the business, among other things, of wholesaling or retailing dietary supplements, cosmetics, foods or similar products, which are the types of tangible property to be purchased from the seller.

State Registration, Seller Permit, or ID # of Buyer:_____ State(s):_____

I further certify that if any property or service so purchased tax free is used or consumed by buyer as to make it subject to a Sales or Use Tax, buyer will pay the tax due directly to the proper authority when state law so provides or inform the seller for added tax billing. This certificate shall be a part of each order which buyer may hereafter give to seller, unless otherwise specified, and shall be valid until canceled by buyer in writing or revoked by city or state.

Under penalties of perjury, I swear or affirm that the information on this form is true and correct as to every material matter. I also agree to provide updated information if my license status changes. I agree to be responsible for all amounts owing for any orders on my account including costs of collection and attorney's fees and that all sales are subject to Company's Terms and Conditions of Sale.

Disclaimer: Healthway Corporation reserves the right, in its sole discretion, to determine which customers may purchase its products, and what selection of combination of products, if any, are available to each approved customer. Healthway Corporation also reserves the right, in its sole discretion, to sell to any party, to refuse to sell to any party, or to cease selling to any party.

I certify that I have read and accept the above and that the information provided above is complete and accurate.

Buyer Authorized Signature:_____ Date:_____

Name:_____ Title:_____