

New Hospital Account Form: Canada



Please complete this form and email to int-orders@biocomposites.com
or fax to 910.350.8072

****FORM MUST BE COMPLETED BY SALES REPRESENTATIVE / DISTRIBUTOR****

DATE: _____ HOSPITAL MAIN PHONE #: _____

HOSPITAL NAME: _____

HOSPITAL STREET ADDRESS: _____

CITY, STATE: _____ ZIP CODE: _____

BILLING STREET ADDRESS: _____

CITY, STATE: _____ ZIP CODE: _____

Distributor Information

Distributorship:		Representative(s) Name:	
Representative Phone No.(s):		Representative(s) Email:	

Product Pricing

**** Must Be Completed or Form Will Be Returned to Rep ****

STIMULAN Kit 600-005	\$	STIMULAN Rapid Cure 620-005	\$
STIMULAN Kit 600-010	\$	STIMULAN Rapid Cure 620-010	\$
genex 5cc 900-005	\$	STIMULAN Rapid Cure 620-020	\$
genex 10cc 900-010	\$	STIMULAN Bullet Mat & Introducer 660-001	\$

Hospital Purchasing & Accounting Information

Purchasing Agent/ Materials Mgmt Contact:			
Phone Number:		Email Address:	
Health System:		GPO:	

A/P Contact:		Payment Terms:	
A/P Phone No:		A/P Email:	
Fax Invoices To:		Email Invoices:	